University of Alberta

The Lived Experience of Pregnancy and Birthing of Women With Histories of Childhood Sexual Abuse

by

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Abstract

This interpretive inquiry addresses the question: *What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?* Its aim - through ongoing and discursive dialogues with women, various literatures, and other sources of information – is a descriptively rich and evocative text that uncovers a deeper understanding of this experience as it is lived, through the themes *living in the wake of childhood sexual abuse*, *response-ability to motherhood*, and *regeneration*.

Living in the wake of childhood sexual abuse reveals how sexual abuse can insinuate itself into a life and etch a body and a psyche with uncertainty and fear, fracture beliefs, and even 'undo' a self. Through the theme of *response-ability to motherhood*, women describe awakening to new ways of seeing and relating to their self and to the weighty responsibility for (an)other's well-being. Those who felt safe and supported often experienced a visceral 'Yes!' to being pregnant. When safety and support were absent however, participants were more likely to feel uncertain about their pregnancies, to feel invaded, and to be re-traumatized. Through this theme too, we see how women's response-ability to pregnancy is coloured by an indelible first-hand 'knowing', about the dangers that exist for children in the world. The third theme, *regeneration*, shows us that pregnancy and birthing can also be a time of personal growth and healing for women with histories of childhood sexual abuse. The women spoke of how carrying, birthing, and caring for a child opened them up to previously unimagined ways of being, to their own lost innocence, and to the delights and joys of childhood, which in turn offered them new opportunities for wholeness and healing.

My hope is that this text, offers nurses and other health care providers a rich and deep understanding of the lived experience of pregnancy and birthing of women with histories of

childhood sexual abuse; that it contributes to the advancement of nursing knowledge; and in these ways, informs the sensitive healthcare of women with histories of childhood sexual abuse.

This work is dedicated to

my sons, Derek Risling and Matthew Risling,

who gave birth to me as a mother

and

to my mother, Thérèse Lanovz Lasiuk,

who showed me ' the way'

Table of Contents

Chapter		Page
I.	**Coming to the Question**	1
	The Call	1
	Orienting to the Question	4
	Defining Moments	4
	Fundamental Assumptions	6
	Childhood Sexual Abuse as a Defining Moment	7
	Sexual Abuse and the Developing Self	8
	Subjectivity	12
	Childhood sexual abuse and the relational self	15
	Childhood sexual abuse and the body	18
	Aim of the Inquiry	20
II.	**Situating the Question: Childhood Sexual Abuse as Psychological Trauma**	22
	Psychological Trauma: Thorns in the Spirit	23
	A Brief History of the Concept of Psychological Trauma	24
	Railway spine, hysteria, and dissociation	24
	Combat trauma	27
	Posttraumatic stress disorder becomes a psychiatric diagnosis	29
	The Nature and Scope of Interpersonal Violence	30
	The Phenomenology of Psychological Trauma	33
	Childhood Sexual Abuse	34
	Health effects of childhood sexual abuse	36
	Implications for health care providers	37
III.	**Situating the Question: Pregnancy and Birthing**	40
	Pregnancy and Birthing as Social Constructions	40
	A brief history of modern maternity care	40
	Managed pregnancies	44
	The pregnant and birthing body	45
	Alternative/natural childbirth movement	47
	The Lived Experience of Pregnancy and Birthing	51
	Oh God, I'm pregnant! Uncertainty begins	52
	(Un)prepared childbirth	53
	The present body	55
	Awakening to Self and Other	58
	'The way of the mother'	58
	Observing and disciplining the body	61
	Worry, blame, and guilt	62
	Giving Birth	63
	Labours of Love	65
	Fear	65
	Pain	68
	Support	71
	The birth of a mother	71

IV. **Review of the Literature on childhood sexual abuse, pregnancy, and birthing** 74
Theoretical Literature 74
Research-Based Literature 77
Autobiographical Accounts 85

V. **Methodology** 87
Qualitative Research Paradigm 87
What is the nature of reality (the knowable)? 88
What is the relationship between the 'knower' and the' knowable'? 90
How should the knower acquire knowledge? 93
Interpretive Inquiry 94
Methods 95
Sources of information 96
Participant recruitment 96
The conversational interviews 97
Ethical Considerations 98
Analysis 99
Appraising an Interpretive Inquiry 103
Ethical validation 105
Substantive validation 106

V. **Pregnancy and Birthing: Women with Histories of Childhood Sexual Abuse Describe Their Experience** 107
Living in the Wake of Childhood Sexual Abuse 108
Shirley: Girl Interrupted 108
Kate: I Have Been Off Balance for a Long Time 118
Response-Ability to Motherhood 126
Elly: I Was Not Ready to be a Mother 126
Chloe: I'm Not Supposed to be a Mother, I'm Just Not Worthy of This 132
Debbie: It's Hard and The Most Incredible Thing You Can Ever do 137
Regeneration 145
Jane: It was a Rebirth For Me ... I Got to be a New Person 145
Sharon: I Have More Love 158

VII. **Living in the Wake of Childhood Sexual Abuse** 167
Living with Profound Disruption and Loss 168
Etched by Uncertainty and Fear 173
Fractured Beliefs 177
The Undoing of a Self 179
Rising from the Ashes: Resilience and Healing 181

VIII. **Response-Ability to Motherhood** 183
Safety, Stability, and Support 183
A 'yes!' to being pregnant 184

Uncertain pregnancy 187
Alien invasion 192
Awash in helplessness 194
A 'deeper bruise' of knowing 195
The tainted mother 198

IX. Regeneration 200
Born 'By Bits' 200
Born Again as Mother 204
A Return to Wholeness 206

X. A 'Good Gestalt' 209
Reflections on the Inquiry Process 209
A 'Good Gestalt' 211
Relevance to Nursing Practice 212
Vulnerability and openness 213
Above all, do not harm 214
Sensitive practice: Substrate for healing 215
Concluding Comments 216

XI. Epilogue 217

References 219

Appendix A Participant Information Sheet 244
Appendix B Participant Consent 246

FIGURE 1. The relationship between brain processes, consciousness, and the autobiographical self

CHAPTER 1

COMING TO THE QUESTION

The Call

Every research project begins with a question and all questions call for a response. The call for this study originated in the following passage:

> *The tears came suddenly, unbidden and unexpected, and I was ashamed. The familiar self-doubt began again. If I could not endure this vaginal exam on my first prenatal visit, how was I ever going to birth a baby? What were these tears about anyway? When my midwife noticed that I was crying, she asked if she had hurt me. I could not explain the sudden terror, the shame and confusion. I decided, as I had decided many times before, that there must be something wrong with me. I wanted her to like me, so I smiled and shrugged my shoulders, wiped my tears away and said, "I'm sorry. I'm OK, really"... When I was about seven months pregnant, I finally found the courage to quietly mention to her that I was afraid of giving birth. I could not tell her why. The closest I could come to identifying the feeling was to say that I was afraid of being out of control. She tried to calm my fears, and casually said that many women are afraid, especially primips. But, she added, women who are the most afraid usually do the best in labor...The only time she let me down was that sunny afternoon in her office when she minimized my fears and dismissed them so easily...Within hours of my son's birth I felt depressed. Had I done it right? Did my midwife still like me? Did my husband respect me? I had complained--a lot! Was I a whiner? Was everyone making fun of me behind my back? I convinced myself that my unmedicated spontaneous vaginal delivery had been a failure. I was not good enough. My baby was so good, so beautiful, so perfect. I was so bad, so ugly, a failure. The crying began again. I read more books, this time on postpartum depression. Nothing I read sounded right to me. I could not explain my*

feelings of loss and shame. And so I did what I always did with my feelings--I hid them. (Christine, 1994)

To a casual observer, Christine's pregnancy was the stuff of a television ad for some sweet-smelling baby product. She had a loving and supportive husband and she looked forward to motherhood with great anticipation. Throughout her pregnancy, she had excellent prenatal care and read everything she could about pregnancy and birthing. With each of her three pregnancies, she also cried for no apparent reason after every prenatal visit. As well, she experienced nausea and vomiting throughout her pregnancy; had long, slow, overdue labours; and debilitating postpartum depression. Christine has a history of incest, something she did not have conscious memory of until after her third pregnancy. In retrospect, this knowledge has helped her to understand a darker side of her childbearing experience – the shame and distrust of her body, her high need for control, and her recurring bouts of depression. Although she experienced them as caring, none of the health practitioners who provided care for her during and after her pregnancies ever asked Christine whether she had a history of childhood sexual abuse.

I encountered Christine's account of her pregnancy and birthing experience quite by accident while doing some research on the internet. Something in what she had written touched me in a way that I could not quite articulate. Over the next few days, I reread the piece several times, carefully searching her words for whatever it was that I that addressed me so personally. At first I thought it was that as a psychotherapist I had worked with many women who, like Christine, had histories of childhood sexual abuse and who struggled with recurrent bouts of depression or other mental health problems. This explanation rang true, because in part, it was their everyday courage that inspired me to enter a doctoral program with the intent of making some meaningful difference to their health and healthcare.

Satisfied that I had identified why her story touched me so deeply, I put the piece aside and yet I could not put it out of my mind. My thoughts repeatedly found their way back to Christine and the other women I had known. The more I thought about them, the more I became aware of a deep sense of injustice at the hypocrisy of it all. On the one hand, Western societies espouse the value of human life and an obligation to protect the vulnerable, while at the same time often failing to take action. I am disturbed and at the

same time fascinated by the pervasive and seemingly intractable refusal to acknowledge the existence of child abuse. What, as Barbara Everett and Ruth Gallop (2001) write, enables us to cling tenaciously to images of childhood as

> sweet smelling babies, chubby hands, dragging teddies, pony rides, science projects, piano lessons, prom dresses, and graduation ceremonies … [and to look away from] the broken bones, chipped teeth, black eyes, burns, unexplained vaginal or anal infections, night terrors, empty stomachs, and lonely hearts. (p. 3)

How can we claim to be a moral society … to be moral individuals, when child abuse exists? How are we able to deny it or minimize its significance despite overwhelming evidence to the contrary? Perhaps what Bertolt Brecht (1976, p. 247) writes is true,

> When evil-doing comes like falling rain, nobody calls out "stop!"
> When crimes begin to pile up they become invisible. When sufferings become
> Unendurable the cries are no longer heard. The cries, too, fall like rain in summer.

As I reflect back on more than two decades of being a nurse, I am particularly unsettled by the thought of individuals – children, women like Christine, men – who may have left encounters with me and other health professionals feeling 'let down'.

A day or so later, the final piece of this puzzle fell, unbidden, into place. My hands were busy with some repetitive task and my thoughts drifted to the birth of my first child. I was young and healthy and apart from some minor back strain, my pregnancy was without complications. I felt confident and like Christine, I looked forward to becoming a mother. My labour began spontaneously 10 days after my expected due date and progressed quickly. Six hours later, in the dawn of November 16, I delivered a healthy baby boy. A few days later, his father and I took him to the motel room that was our temporary home.

Eight weeks before that, we had moved hundreds of miles away from our families to a small northern B.C. community, in search of adventure. Renovations to the apartment that was promised to us met one delay after another and although I struggled to remain positive, I was disappointed that these cramped quarters would be our son's first home. Subtly, over the next few days a dense greyness settled over me, infusing every cell of my body with lead. The days passed in a blur. My next clear memory was six

months later when I noticed the bright May sunshine; the greyness was gone and I was myself again.

This experience taught me first hand what Cheryl Tatano Beck (1999) means when she calls postpartum depression as 'the thief that steals motherhood'. As I look back on that time, I see that I had been depressed and had lost six of the most precious months of my life. The thing that lingers with me the most is that no one seemed to notice - not my husband, not my family or friends, not my physician, and not the public health nurses. When I think of this younger self, alone and vulnerable, I can immediately locate the part of me that resonates the most deeply with Christine. This part of me understands what it is to be without the words or a voice to say that something is terribly wrong. It is also the part that compels me to understand more about the experience of pregnancy and birthing of women who have histories of childhood sexual abuse.

Orienting to the Question

Defining Moments

> *As a child, I was mesmerized by the large white-faced clocks that were standard issue in all elementary school classrooms. On many occasions my eyes would follow the second hand as it ratcheted from notch to notch, passing by each number 1 through 12, steadfastly marking the passage of time. If I held my breath, I might even hear the clock's faint ticking, which I imagined to be the footfalls of 'time marching on'. Somewhere between the number 12 and the first notch on the way to the number 1, I could see that one minute ended and another one began. Curious about this transition, I devised a ritual to help me pinpoint the threshold where the future becomes the present and the present slips into the past. Is it possible to feel one moment becoming the next? When it passes, does a minute disturb the molecules in the atmosphere like a gentle breeze against the cheek? Would remnants of the present linger ever so slightly before dissipating, like my teacher's perfume or the rustle of her skirt as she slowly makes her way between our desks? Could I actually feel myself getting older... notice myself changing into a different person? If I could situate myself at the intersection of past, present, and future perhaps*

something extraordinary would happen. Maybe I could step through the looking glass into a new reality or looking into the face of God, like the child saints in my catechism class. As the second hand approached the number 11, I would blink a couple of times in rapid succession and then force my eyelids open wide to await the transcendent event. No matter how hard I concentrated though, before my brain could think the word 'Now!' the opportunity was gone. One moment seemed no different from the next. After several attempts, I would lose interest and turn my attention elsewhere. ~ G. Lasiuk

What stays with me from these childhood experiences is an understanding that although life is lived as a series of discrete moments, they all seem to blur together. From our first breath until our last, they follow in lock step, one after the other. Each new minute dissolves into the one before it and in doing so, becomes indistinguishable from it. In every life however, a handful of minutes stand out from the others, their details remaining fixed in memory for years afterward. Some people refer to these as 'defining moments', perhaps because they delineate the boundaries of 'before' and 'after' some significant event. Defining moments change the course of a life and disturb pre-existing notions of self, other, and world.

Writing in the second person, the American author bell hooks (1997) describes a defining moment in her childhood that occurred when she saw her father brutally beating her mother.

That night changed her forever, changed everything about her capacity to trust in the universe. Her bond with the world of the everyday and the concrete was already a tenuous bond. On this night it snapped. Nothing could ever be the same. She could never trust that everything would not fall apart - it was then that she decided it was better not to try to hold on to things, just let them go... She wanted no part of a world where hearts could be broken, and bodies could fall in the name of love. She had been a witness. (p. 12-13)

Much of bell hooks' life after that moment is lived in relation to it. Even though it was years ago, the change that occurred in the space between 'before' and 'after' remains

salient for her and continues to affect her fundamental assumptions about the world and her place in it.

Fundamental Assumptions

These fundamental assumptions are called different things by different people, William James (1907, p. 4), for example, wrote that the

> [p]hilosophy which is so important in each of us is not a technical matter; it is our more or less dumb sense of what life honestly and deeply means ... it is our individual way of just seeing and feeling the total push and pull of the cosmos".

The psychiatrist, John Bowlby (1969, 1973) referred to them as *working models* that each of us constructs about our self and the world and which give meaning to our perceptions. Parkes (1975, p. 132) used the term *assumptive world* to describe the "strongly held set of assumptions about the world and the self which is confidently maintained and used as a means of recognizing, planning and acting ..." Similarly, Epstein (1984) says that each of us has a *personal theory of reality*, which includes both a *self-theory* and a *world-theory*. This "personal theory of reality does not exist in conscious awareness, but is a preconscious conceptual system that automatically structures a person's experiences and directs his or her behavior" (p. 65).

According to Ronnie Janoff-Bulman (1992), our fundamental assumptions are the "bedrock of our conceptual system" (p. 5); they are the foundation of our most basic beliefs about our self, the world, and the relationship between the two. Because they are abstract, general, and - like the air we breathe - ubiquitous, we are largely unaware of them and unlikely to question them. They simply exist in our minds as *the way things are*. Janoff-Bulman further believes that unless confronted with evidence to the contrary, most of us share some version of the following three fundamental assumptions – "The world is benevolent. The world is meaningful. The self is worthy" (p. 6). Two important features of these beliefs are that they are formed early in life as preverbal representations and it is only as we get older and more self-reflective that we gain the ability to frame them in language. A second feature is that, because these fundamental assumptions have a close association with our emotional system, they colour our mood. As Janoff-Bulman put is, "[c]learly it feels good to believe that we are decent and the world is benevolent

and meaningful" (p. 30). A logical corollary however, is that bad things do not happen to good people; bad things happen to bad people who bring it upon themselves.

Childhood Sexual Abuse as a Defining Moment

For many women, the experience of childhood sexual abuse is a defining moment that ruptures their fundamental assumptions about the world as good and meaningful and about themselves as worthy. Somewhere between 'before' and 'after' they are catapulted into a strange and unpredictable new existence where nothing is as it was. Sylvia Fraser (1987) describes such a moment in her book, *My Father's House*:

> *My daddy plays with my belly button, my daddy plays with my toes as he did when I was little: "This little piggy, that little piggy ..." Now I lie on my daddy's bed, face buried in his feather pillow. I shiver because the window is open, the lace curtains are blowing and I haven't any clothes on. My daddy lies beside me in his shorts and undershirt, smelling of talcum. He rubs against me, still hot and wet from his bath. My daddy breathes very loudly, the way he does when he snores, and his belly heaves like the sunfish I saw on the beach at Van Wagners. Something hard pushes up against me, then between my legs and under my belly. It bursts all over me in a sticky stream. I hold my breath feeling sick like when you spin on a piano stool till the seat falls off. I hear God say: "You've been dirty, go naked!" When I pull my daddy's pillow over my head I get feathers up my nose (p. 8)*

Like Christine (1994), Sylvia Fraser compartmentalized the abuse and set it apart from her conscious memory. While this did give her day-to-day life a semblance of normalcy despite the ongoing presence of a big and disturbing problem that she had no ability to understand or reconcile; it did nothing to mediate her body's visceral response. From the moment the abuse started, Sylvia Fraser's life was full of fear – fear of the dark, fear of demons and monsters lurking in the shadows, but most of all fear that her father and mother would cease loving her for what *she* had done. That fear followed her into adulthood where it insidiously permeated all aspects of her life. She would not remember the abuse until decades later, when a conversation with friends breached the chiasm and allowed memories of it to creep back into consciousness.

How can we understand these discontinuities described by Sylvia Fraser (1987), bell hooks (1997), and Christine (1994)? What occurred in one moment that left them so drastically different the next? What nature of event caused bell hooks to instantaneously redefine the universe as untrustworthy and Sylvia Fraser and Christine to 'forget'? Is this type of 'forgetting' the same as the 'forgetting' that leaves homework assignments and chores undone or is it something different? If it is different, what purpose does it serve? What is it like to live, having 'forgotten' a significant aspect of one's experience or one's self?

Although not all defining moments are associated with traumatic events, childhood sexual abuse often is. The literatures on child development and neurobiology offer some insights into how the experience of childhood sexual abuse can-through its effects on cognition, affect, physiology, and behaviour-alter the course of a child's life.

Sexual Abuse and the Developing Self

In the womb, the fetus exists in an environment exquisitely suited to meeting her[1] requirements for nourishment, oxygen, and safety. Birth wrenches her, naïve and helpless, from this effortless existence and delivers her unprepared, into a foreign place, where for the first time she experiences the pain of need. Although birth physically separates the infant from her mother, she has no consciousness of her self as a separate being.

Yet unaware of her body as a separate entity, the infant's early experience of the world is paradoxically mediated through her bodily needs. In the early months of life, she has no sense of herself a person who is hungry, cold, or uncomfortable; she *is* hunger, she *is* cold, she *is* distress. At this stage in her life, she exists only in relation to those needs. If caregivers respond consistently and well, the infant comes to know the world as nourishing, warm, and responsive.

Winnicott (1986) used the term *holding* to describe the first phase of infant development, in which the mother[2] and child are symbiotically engaged. In this context, holding extends far beyond the actual physical holding of the infant to include the total

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[1] Although boys are also sexually abused, because this inquiry is about the female experience of pregnancy and birthing, the female pronoun is used throughout.

[2] Again, because this is a study of women's experience I use the word 'mother' when the terms 'primary caregiver' or 'parent' would be just as apt.

environment (i.e., the physical realm, the relational space, and time). Infant and mother are subjectively merged; they hold and are held by one another. The infant, in a state of "absolute dependence" (1986, p. 242), draws her mother to her and the mother, preoccupied by her infant, attunes her whole being to her baby's needs. In a footnote in a paper on the parent-infant relationship, Winnicott (1986, p. 235) wrote, "I once said: 'There is no such thing as an infant', meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant".

Winnicott (1953) believed that if the mother's care is reliable in this phase – if she is a *good enough mother*[3] – she is almost completely adapted to her baby's needs. When the infant cries from hunger, cold, or pain, the mother responds, which enables the baby to develop a sense of *subjective omnipotence* – the transitory illusion of all-powerfulness that grows out of the experience of a world that exists only in relation to ones needs. Imperceptibly, through the dynamic of holding and being held,

> … there comes into existence what might be called a limiting membrane, which to some extent (in health) is equated with the surface of the skin, and has a position between the infant's 'me' and his 'not-me'. So the infant comes to have an inside and an outside, and a body-scheme… [and] most important … the dawn of intelligence and a beginning of a mind … (1986, p. 241)

It is a short leap from here to understand what Winnicott (1972) later meant when he located the primary identification of self in the body:

> For me the *self*, which is not the *ego*, is the person who is me, who is only me, who has a totality based on the operation of the maturational process. At the same time the self has parts and, in fact, is constituted of these parts. These parts agglutinate from a direction interior-exterior in the course of the operation of the maturational process, aided as it must be (maximally at the beginning) by the human environment, which holds and handles and, in a live way, facilitates. The self finds itself naturally placed

---

[3] In contrast to the *good enough mother*, who gradually adapts less and less completely to her infant's needs, a 'perfect' mother continues to respond immediately to baby's every demand and in doing so may impede her child's development.

in the body, but may in certain circumstances become dissociated from it or the body from it. (p. 16)

From this, we can see too why Erik Erikson (1968) identified infancy as the critical time for developing a basic sense of trust, which he viewed as the "fundamental prerequisite of mental vitality" (p. 96). Similar to Winnicott, Erikson believed that the quality of maternal-child interactions is the ground for establishing our basic assumptions about our self, other people, and the world in general. In this sense, while pregnancy gives an individual life, it is through interactions with the social and physical environments that she achieves selfhood.

In his writings about the social self, William James (1890, 1984) differentiated between two aspects of the self - the *I-self* and the *me-self*. The *I-self* is the actor or knower, whereas the *me-self* is the object of one's knowledge, it is "an empirical aggregate of things objectively known" (1890, p. 197). James believed that the *me-self* is comprised of three separate but interrelated aspects: the material self (those aspects of existence over which we feel a strong sense of personal ownership, including our body, our family, and our possessions); the social self (our relationships with others), and the spiritual self (our subjective sense of being-in-the-world). In contrast, the *I-self* is the seat of self-awareness, agency, continuity, and coherence – the stable sense of being the same person (self) that I was yesterday.

Susan Harter (1999) contends that childhood sexual abuse interferes with the development of both *I-self* and *me-self* functions, particularly the sense of personal agency, access to and understanding of internal states (e.g., thoughts, feelings, and needs), and constancy. The latter resonates closely with Daniel Stern's (1985) notion of *continuity*.

Stern (1985), a psychiatrist and infant researcher, is concerned with the development of selfhood and subjectivity. Stern's thesis is that human subjectivity emerges from four foundational senses of self. The first of these, the *emergent self*, develops between birth and 2 months and provides a platform for the continually evolving self. During this time, infants are involved with taking in sensory data from the environment and organizing it into patterns. According to Stern, because they cannot yet differentiate among sensory domains, the emergent self is unified and global. Young

infants experience sensations, perceptions, actions, cognitions, internal states of motivation, and states of consciousness directly in terms of intensities, shapes, temporal patterns, vitality affects, categorical affects, and hedonic tones. Through their interactions with the world, they gradually and systematically order these elements of experience into *self-invariant* and *other-invariant* constellations. This global, subjective world of emerging organization becomes the basis for subjectivity.

At around 2-3 months of age, Stern (1985) believes that infants undergo a qualitative change; their ability to make eye contact, to smile, and to vocalize signals the advent of the second foundational sense of self, the *core self*. As well as becoming more overtly social, between 2 and 6 months, infants' attend differently to the world as evidenced by altered visual scanning patterns. Their motor behaviour becomes intentional and their diurnal hormones stabilize, as do their sleep-wake cycles. As this *core self* begins to function in a more integrated manner, infants experience (1) self-agency, (control over her actions, volition, and expectancy of the consequences of her action); (2) self-coherence (the sense of being a whole, physical self with boundaries and possessing a locus for action); (3) self-affectivity (experiencing inner qualities of feelings or affects that go along with other qualities of self); and (4) self-history or continuity (the sense of being the same self over time; of being the same person even as one grows and develops).

It is at this stage of development that memory becomes an important factor in maintaining a whole and integrated, *core self* across time. Real-time lived experience does not have a complete memory structure until it is over. It is only after an experience has ended that it is encoded into episodic memory. Tulving (2002) believes that episodic memory makes

> possible mental time travel through subjective time, from the present to the past, thus allowing one to re-experience through noetic awareness, one's own previous experiences… The essence of episodic memory lies in the conjunction of three essences – self, autonoetic awareness, and subjectively sensed time. (p. 5)

According to Stern (1985), episodic memory of a particular event is stored as "a small, but coherent chunk of lived experience" (p. 95) including sensations, perceptions, body sensations, thoughts, affects, intents, and causal relationships. Because episodic

memory is dynamic, it permits indexing and re-indexing of events in a fluid fashion, which creates a sense of a continuous, core self over time.

Stern's (1985) third sense of self is the *subjective self*, which develops between 7 and 15 months when the infant begins to recognize that "he or she has a mind and that other people have minds as well" (p. 124). The emergence of this sense of self-in-relation-to-others evolves from interactions between the infant and her caregivers, which provide the substrate for intersubjective relatedness. From this point forward, the infant experiences empathic human interaction not merely as physical comfort or soothing, but as a bridge between two minds. With this capacity for intersubjectivity comes the potential for psychic as well as physical intimacy. It is in this context that interactions with caregivers become a central feature of the infant's subjective experience of self. Caregivers' attitude, behaviour, and emotional tone all directly influence the infant's cognitive sense of self and her feelings about her self.

The fourth of Stern's developing self, the *verbal self*, occurs around 15 – 18 months as the infant acquires language. When young humans can symbolize and share meanings about their self and the world through words, verbal relatedness is possible. This qualitatively novel domain has almost limitless possibilities for interpersonal exchanges. In addition to creating the potential for intersubjective understanding, it enables the infant to objectify the self (i.e., to create and relate to the *me-self*) and to be self-reflective. From this time forward, autobiographical narratives play a major role in defining the self.

Stern (1985) thinks that these four senses of self and their attendant domains of relatedness remain active throughout the lifespan. Once all are developed and functional, they interact with each other, enabling the individual to subjectively experience the world simultaneously in all domains.

Subjectivity

One way to understand subjectivity - the self that perceives and experiences the world - is as a phenomenon of the mind, one that arises from structures and activities of the brain (Mesulam, 1998). In work that he calls *interpersonal neurobiology*, Daniel Siegel (1999), integrates developmental psychology and cognitive neuroscience to explain how the brain interacts with the external world to create mind.

A complex system of integrated parts, the brain is composed of an estimated one hundred billion neurons, each with direct connections to an average of 10,000 other neurons (Kandel & Schwartz, 1992). This means that there are approximately one million billion of these points of connection or synapses, which enable it to function as an integrated whole. At birth however, the newborn brain is the most undifferentiated organ in the body (Siegel), its development and specialization occurs in the early years of life through the interplay of genetics and experience.

In utero, the brain is genetically programmed to produce an over abundance of neurons that are the substrate for developing mental processes including emotion, memory, motor behaviour, and interpersonal relationships (Schore, 1994). While the genes contain information for the general organization and structure of the brain, experience governs which genes are expressed, to what degree, and when. Gene expression results in the production of proteins that foster neuronal growth and the formation of new synapses. Siegel (1999, p. 13) describes brain development as an "experience-dependent" process in which experience (the activation of specific groups of neurons) creates new pathways and strengthens existing ones. For example, animal research demonstrates that enriched environments increase the number of neurons and the density of synaptic connections in the hippocampus, an area associated with learning and memory (Hockfield & Lombroso, 1998).

The capacity of the brain to change in function and organization is called *plasticity* and occurs in response to pre- and postnatal experience, drugs, hormones, aging, diet, disease, and stress (Gonul, 2003; Kolb, Gibb, & Robinson, 2003). The resultant changes in the nervous system (typically accompanied by alterations in behavioural, emotional, and psychological function) are variously labelled learning, memory, addiction, maturation, and recovery. Although neuroplastic changes occur during all stages of life, the prenatal period and childhood are especially critical times in brain development. There is evidence, for example, that traumatic experiences early in life affect the limbic system, the hypothalamus, and the pituitary, all of which play a role in physiological homeostasis and stress response (Siegel, 1999).

Interaction with the external world activates neural pathways simultaneously in all sensory modalities to create a transient neural map or neural pattern of one's immediate

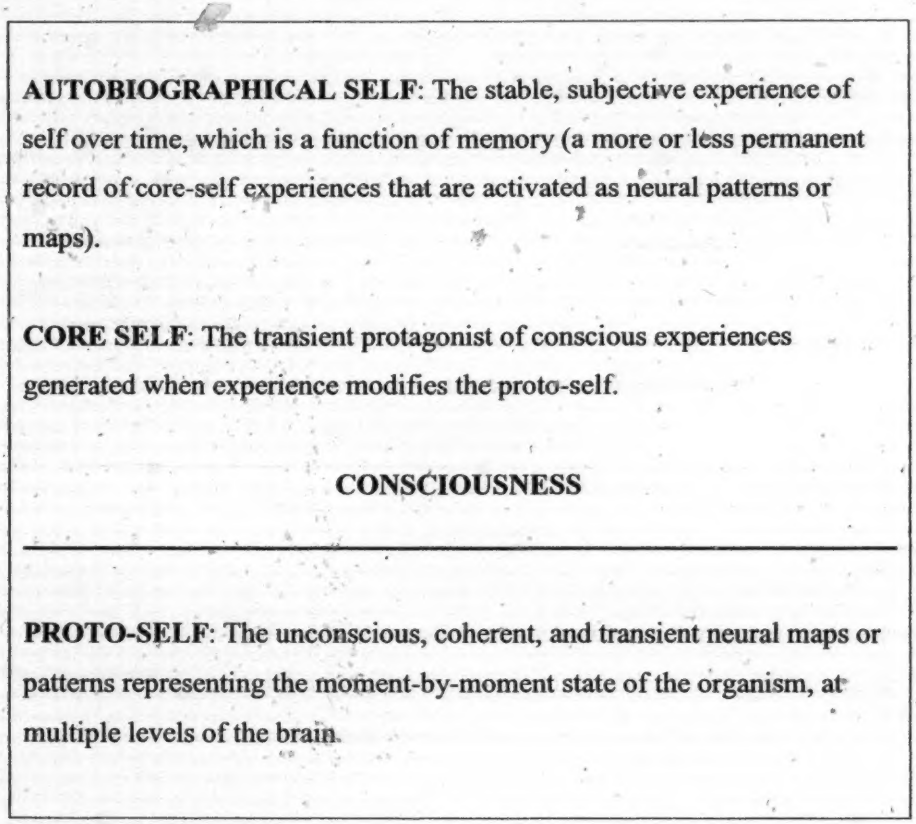
experience. A neural map is a "specific pattern of neural firing in a particular region – that serves to create a 'mental image', such as a sensory image, or the linguistic representation of a concept or object" (Siegel, 1999, p. 69).

These neural maps constitute part of what Damasio (1999) calls our *proto-self*, the myriad brain processes "which continually and unconsciously maintain … the living body along its many dimensions" (p. 22). This proto-self is the unconsciousness self that is reconstructed in each moment of lived experience as sensory data impinges on the brain. Consciousness in the moment – what Damasio refers to as the *core-self* – occurs when an object in the world modifies the proto-self. In other words, the *core-self* is a second-order neural map of the *proto-self being modified by experience*. Because the brain is continually exposed to the objective world, experience of one's *core-self* (consciousness) is seamless. Through mechanisms of implicit and explicit memory (i.e., processes by which the brain encodes, stores, and retrieves mental representations of experience) significant aspects of our core consciousness become part of our permanent mental record of core-self experiences that Damasio labels the *autobiographical self*. The *autobiographical self* is

> [c]onstituted by implicit memories of multiple instances of individual experiences of the past and of the anticipated future … Autobiographical memory grows continuously with life-experience but can be partly remodelled to reflect new experiences. Sets of memories which describe identity and person can be reactivated as a neural pattern and made explicit as images whenever needed. Each reactivated memory operates as 'something-to-be-known' and generates its own pulse of core consciousness". (p. 174)

The figure below crudely illustrates the relationship between brain processes, consciousness, and the autobiographical self, all of which interact to produce a stable subjective experience of self over time.

FIGURE 1. The relationship between brain processes, consciousness, and the autobiographical self (Adapted from Damasio, 1999, pp. 174-5)


AUTOBIOGRAPHICAL SELF: The stable, subjective experience of self over time, which is a function of memory (a more or less permanent record of core-self experiences that are activated as neural patterns or maps).
CORE SELF: The transient protagonist of conscious experiences generated when experience modifies the proto-self.
CONSCIOUSNESS
PROTO-SELF: The unconscious, coherent, and transient neural maps or patterns representing the moment-by-moment state of the organism, at multiple levels of the brain.

From this very brief discussion of the neurobiology of experience and the development of self, we get some sense of how events in the external world can alter structures and processes in the brain and mediate a girl's subjective experience of self. With this in mind, I will focus on the mechanisms by which the trauma of childhood sexual abuse affects the developing self in relation to other people and the world in general.

Childhood sexual abuse and the relational self

Mardi Horowitz (1997) characterizes a traumatic event as one that cannot be assimilated into an individual's schema of self-in-relation-to-the-world. Such an event disrupts an individual's physiology; the nature and meaning of their relationships with others; and their belief in the world as safe and predictable. Like an up-ended jigsaw

puzzle, bits of information about the self and the world no longer relate to each other in the same way that they once did; things previously taken for granted become uncertain. Everything that was once known comes into question and must be re-evaluated. The situation is further complicated for children because they lack experience, are egocentric, and view the world in all or none terms. When something horrific occurs and a child asks *'Why did this happen to me?'* the response that makes most sense is that *'Bad things happen to bad people'*. As Lenore Terr (1994) explains, young children will often use the psychological defence mechanism of splitting as a way to compartmentalize parts of the self that are perceived to be negative or bad. Splitting provides metaphorical blinders to keep all contradicting evidence out of awareness (Siegel & Spellman, 2002).

Sylvia Fraser offers an example of this. As an adult writing her novel *Berlin Solstice*, Fraser (1984) was grappling with two questions - *'How could the Nazis have done what they did?'* and *'How could the decent Germans have let them?'*. In the process of working through issues of abuse of power, betrayal of trust, violence, and survival in a corrupt world for her novel, she began to question these same issues in her own life. Examining the horrors of the Holocaust forced Fraser to confront two much more personal questions - *'How could my father have done what he did?'* and *'How could my decent mother have let him?'*. In the following passage, she describes how, as a child, she managed her conflicting experiences of self:

> *When the conflict caused by my sexual relationship with my father became too acute to bear, I created a secret accomplice for my daddy by splitting my personality in two. Thus, somewhere around the age of seven, I acquired another self with memories and experiences separate from mine, whose existence was unknown to me...Even now, I don't know the full truth of that other little girl I created to do the things I was too frightened, too ashamed, to repelled to do, the things my father made me do... She loved my father, freeing me to hate him. She became his guilty sex partner and my mother's jealous rival, allowing me to lead a more normal life. Like estranged but fatal lovers, we were physically attuned. She telegraphed messages to me through dreams we shared. She leaked emotions to me through the body we shared.* (Fraser, 1987, p. 15)

It impossible to understand the effects of childhood sexual abuse on the developing self, without also considering the importance of relationships in the life of a child. Much of what we know about relationships is based on attachment theory, which emanates from the individual and collaborative work of John Bowlby (1969, 1973, 1980) and Mary Ainsworth (1969, 1985, 1989; Ainsworth, Blehar, Waters, & Wall, 1978). Building on concepts from ethology, cybernetics, information processing, developmental psychology, and psychoanalysis, Bowlby theorized that infants are born with an attachment behavioural system, which is one of four innate behavioural systems that have evolved to safeguard infants' survival. The function of this attachment behavioural system is to regulate affect and to protect the infant from physical and psychological harm during its long period of dependency.

When attachment behaviours are successful, the infant establishes and maintains secure attachments. Secure attachments have four defining characteristics: *proximity maintenance* (the desire for physical closeness to the attachment figure); *separation distress*; *safe haven* (seeking out the caregiver when distressed or anxious); and *secure base* (an internal schema of self-with-attachment-figure that furnishes the infant with a sense of security, enables her to explore the world). Attachment behaviours change as the child matures and develops. Young infants cry, reach out, or cling to their primary caregivers. Later when they are mobile, they actively approach caregivers, follow them, or climb into their laps. Although toddlers leave their caregivers to explore the world, they maintain a sense of connection and security through eye contact, verbal exchange, or by physically returning to them (Lieberman, 1993).

Bowlby (1969, 1973, 1980) believed that secure attachment hinges on reciprocity. If the infant's attachment behaviours are matched by a reciprocal set of care giving behaviours from the mother and important others, strong affectional bond develop that serve as a template for subsequent relationships. An infant whose caregivers respond quickly, sensitively, and consistently sees her self as worthy of the attention and assistance of others. She develops an internal *working model* of her self-in-relation-to-others and comes to anticipate that others in her life will respond to her positively when she needs something. As we saw from Stern's (1985) work, it is through these positive experiences that the infant's autobiographical self incorporates qualities of agency,

coherence, affectivity, and continuity. In contrast, those infants whose caregivers do not respond appropriately and consistently to signals for help construct internal working models of themselves as lacking agency and coherence.

Bowlby (1969) thought of attachment bonds as a specific type of a larger class of bonds that he and Ainsworth (1989) described as *affectional bonds*. Ainsworth identified five criteria for affectional bonds between individuals and a sixth criterion for attachment bonds. Affectional bond are long lasting; involve a particular other who is not interchangeable with anyone else; are emotionally significant; engender the desire to maintain proximity with the other; and result in sadness or distress during separation. In addition, in an attachment bond, the individual seeks security and comfort in the relationship.

Childhood sexual abuse and the body

Although developmental psychologists and neurobiologists may view the mind/self-body as unified, Western sensibilities are infused with the notion - handed down from Plato, St. Augustine, and Descartes - that they are ontologically distinct. The earth-bound body, ruled by base instinct and primitive need, is variously cast "as animal, as appetite, as deceiver, as prisoner of the soul and confounder of its projects (Bardo, 1993, p. 2). Viewed in this light, the body is not to be trusted, but to be controlled and disciplined, in the service of the higher pursuits of the essential inner self, which is synonymous with the mind, spirit, and/or the soul. Plato (1953) makes this imminently clear in the Phaedo when he says, "nature orders the soul to rule and govern and the body to obey and serve" (80c). To achieve this sovereignty and protect itself from the distractions of the flesh, the mind (soul) must exercise strict restraint over the desires and hungers of body.

This mind-body duality is particularly problematic for women in the Western world, because "the mucky, humbling limitations of the flesh" (Dinnerstein, 1976, p. 133) are intertwined with our notions of femininity. The teachings of St. Augustine (AD 353-430) were especially influential in shaping ideas about women, their bodies, and their place in society. Augustine wrote that two kinds of people inhabit the world: sinners, who live according to the flesh, and the good, who follow God's laws. He further believed that the existence of evil in the world was a direct result of Eve's fall from grace

in the Garden of Eden. This dichotomized mind and body in Christian thought and drew an indelible line between the sexes. Things of the mind fell to the domain of men. In contrast, women - the descendants of Eve - were ever associated with the body carnal, moral weakness, and sin.

Because these attitudes toward women were woven through Christian doctrine, they permeated Western European culture during the middle Ages (AD 476-1450). On the other side of the globe, however, in the Eastern Church of Constantinople, the cult of the Virgin Mary flourished (Nevid, Fichner-Rathus, & Rathus, 1995). In that part of the world Mary (and by extension all women) was seen as good, gracious, and loving. Crusaders returning from the holy wars carried this new image of women back home with them, introducing a split into the Western conceptualizations of the essential female nature.

Views of women polarized around two images - Eve, the temptress who represented the carnal nature of femininity and the saintly Madonna. The schism presented women with two ways of being, neither one particularly desirable. To follow Eve is to be ruled by the flesh, to be vulnerable to temptation, immoral, and a danger to oneself and to men. On the other hand, the Madonna has no existence apart from her role as mother and nurturer. In either scenario, women must reject a part of their self. They can choose to be morally corrupt and indulgent of their bodies or self-less nurturers who exist only to serve others.

Delmore Schwartz (1988), in a poem titled *The Heavy Bear That Goes with Me*, uses the metaphor of the body as a 'heavy bear' to describe the otherness of the body in relation to self. The poem laments the burden that the earthbound body places on the human mind.

"the withness of the body" --Whitehead

The heavy bear who goes with me,
A manifold honey to smear his face,
Clumsy and lumbering here and there,
The central ton of every place,
The hungry beating brutish one

In love with candy, anger, and sleep,

Crazy factotum, dishevelling all …

Schwartz employs Alfred North Whitehead's notion of 'the withness of the body' as epigraph, to underscore the paradoxical nature of the mind–body relationship: connected but separate, intimate, yet foreign. In her analysis of the work, Bardo (1993, p. 2) muses, that the body which is

> not 'me' but 'with' me is at the same time the body that is inescapably 'with me'. Like a Siamese twin, neither one with me nor separable from me, my body has 'followed me since the black womb held,' moving where I move, accompanying me in every act. Even in sleep, 'he' is 'breathing at my side.' Yet, while I cannot rid myself of this creature, while I am forced to live with 'him' in intimacy, he remains a strange, foreign presence to me: 'private,' 'near' yet 'opaque'.

How does childhood sexual abuse affect this self-body relationship? Is it possible to love and care for a body that was mistreated by important others? Can a woman love her self, if she hates or fears her body? In her exploration of sexuality among adult women with histories of incest, Elaine Westerlund (1992) learned that almost three quarters (72%) of the women she spoke with had negative and/or distorted perceptions of their body. These women described their bodies such as 'dirty', 'nasty', 'bad', 'evil', 'out of control', 'untrustworthy', and 'the cause of the abuse'. What is the experience of a 'self' who exists in a body that is hated and mistrusted? And what happens in pregnancy when 'the Madonna' and 'the temptress' inhabit the same body? What is it like for women to live in a "female body [that] is impure, corrupt, the site of discharges, bleedings, dangerous to masculinity, a sources of moral and physical contamination, 'the devil's gateway' … [and at the same time be] mother … beneficent, sacred, pure, asexual, nourishing … (Rich, 1986, p. 34). Can pregnancy be a sacred time when women reconcile this schism or is it another assault on the body?

Aim of the Inquiry

While pregnancy and childbirth are profound events for all women, those with histories of childhood sexual abuse may encounter unique challenges that have implications for their sense of self, their relationship with their body, their health, and the

health of their infants. The aim in the interpretive inquiry is to address the question: *What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?* My goal is to create - through prolonged and discursive engagement with individuals, texts, and other sources of information - a descriptively rich and evocative text that reveals the lived meanings of pregnancy and birthing among this group of women. It is hoped that this endeavour will allow others, as well as me, to gain a deeper understanding of the experience; that it will contribute to the advancement of nursing knowledge, and that it will inform the sensitive health care of women with histories of childhood sexual abuse.

CHAPTER 2

SITUATING THE QUESTION: CHILDHOOD SEXUAL ABUSE AS PSYCHOLOGICAL TRAUMA

> The body is an object in which we are all privileged, or doomed, to dwell, the source of feelings of well-being and pleasure, but it is also the site of illness and strains… [I]t is an action system, a mode of praxis, and its practical immersion in the interactions of day-today life is an essential part of sustaining a coherent sense of self-identity. (Giddens, 1991, p. 99)

The sociologist Anthony Giddens (1984, p. xxxii) coined the term "double hermeneutic" to describe the "mutual interpretive interplay between social sciences and those whose activities contribute to its subject matter". In his view, *social actors* (i.e., human beings) are also *social theorists*, who develop and modify their understandings of the world through their experience of living in that world. Likewise, *social theorists* are also actors who live in the same world and whose theories about the world shape their own and others' experience of it. Initially, the theories that social theorists develop about the world are second order in nature, but may become first-order if they are appropriated into the fabric of social consciousness. What Giddens is saying is that through our being-in-the-world that we all participate in the co-creation of social meaning(s). The lifeworld is simultaneously the stuff of lived experience and the source of concepts, constructs, theories, etc., which in turn shape our experience and understanding of that world.

We can see an example of this in what Scott (1995) calls the reification of childhood sexual abuse, which occurred within the past two decades. To *reify* is to regard an abstraction as a material or concrete thing (Simpson, 2007). Scott contends that between 1990 and 2000, the phenomenon of childhood sexual abuse came into being as a social entity. As evidence of this, he points to the ease with which we now speak of childhood sexual abuse as if it exists as an identifiable thing in the world. When we encounter stories about it in the newspaper, on television, or see it portrayed in a movie, we recognize it as a possible (if not common) human experience. The journey toward this recognition is a long and fascinating one and knowing a bit about it may help to explain the resistance to accepting that the frequency of childhood sexual abuse is alarmingly

high, that it does harm the whole self (body, mind, and spirit), and that this harm has clear implications for health and healthcare.

Developing an understanding of any human experience involves the dialectical process of moving back and forth between an experience and making meaning of that experience (theory); between our observations and how we capture and communicate these observations (non-fiction and fictional writing, film, art); between the particular and the whole. To that end, this chapter briefly examines the history and controversies surrounding the concept of psychological trauma, the nature and scope of interpersonal violence, the phenomenology of psychological trauma, and concludes with a discussion of the health effects of childhood sexual abuse. Chapter 3 broadly explores women's experience of pregnancy and birthing, while Chapter 4 reviews the literature concerning pregnancy and birthing among women with histories of childhood sexual abuse. Together these chapters provide a context for understanding how childhood sexual abuse might influence women's experience of pregnancy and birthing.

Psychological Trauma: 'Thorns in the Spirit'

The word *trauma* derives from the Greek word for wound. In its original meaning, a wound was a physical injury to the body by some external agent (Simpson, 2007). The notion of trauma then, speaks to physical being in the world and to human vulnerability in that world.

Most of us can relate to the experience of physical trauma – the wounding of our bodies. As I write this, I am sporting a flesh-coloured band-aid on my left thumb; it covers the cut I sustained while chopping vegetables for last night's dinner. The faint scars on my right forearm, above my left eyebrow, and in the centre of my forehead are all remnants of other minor wounds I have acquired throughout my life. In full view of where I sit writing is a large tertiary care hospital, much of which is dedicated to the healing of wounded bodies. As well as having millions of dollars worth of sophisticated diagnostic and monitoring equipment, the hospital employs teams of specially trained personnel who work around-the-clock to providing care to the wounded. What all of this points to, is that wounding of the body is part of our every-day experience. We do not question that it occurs or that it can have long-lasting effects because we have direct experience with the scars, loss of sensation, and motor disturbances that are the sequelae

of physical trauma. Historically however, there has been resistance to the idea that events in the world can wound parts of the self not visible to the eye.

The American psychologist, William James, was among the first to extend the notion of trauma beyond the physical realm. In his 1894 review of Pierre Janet's work on hypnosis in the treatment of dissociative states, James wrote,

> Certain reminiscences of the shock fall into the subliminal consciousness, where they can only be discovered in 'hypnoid' states. If left there, they act as permanent 'psychic traumata', *thorns in the spirit*, so to speak [italics added]" (p. 199).

Like thorns left unattended in the body, these 'thorns in the spirit' can fester, releasing toxins that spread to distal sites.

A Brief History of the Concept of Psychological Trauma[4]

Railway spine, hysteria, and dissociation

A perusal of titles in the self-help section of any bookstore or the topics of television talk shows on any given day should be enough to convince us that psychological trauma exists as part of the human condition. However despite many accounts of how terrifying and/or life-threatening events such as war, torture, physical and sexual assault, natural disasters, and accidents can have lasting effects on the human mind, body, and soul (Birmes, Hatton, Brunet, & Schmitt, 2003; van der Kolk, Weisaeth, & van der Hart, 1996), mental health professionals resisted the notion until quite recently. As Judith Herman (1992, p. 7) notes,

> the study of psychological trauma has a curious history – one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of inquiry have been taken up and abruptly abandoned, only to be rediscovered much later. (p. 7)

Bessel van der Kolk and others (1996) attribute this to psychiatry's unwillingness to acknowledge that experiences in the world can "profoundly and permanently alter people's psychology and biology" (p. 47). Herman however, believes that this pattern of

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[4] A version of the material in this section has been published in Lasiuk, G. C., & Hegadoren, K. M. (2006). Posttraumatic stress disorder Part I: Historical development of the concept. *Perspectives in Psychiatric Care, 42*(1), 13-20

intermittent forgetting has a darker side. Researchers and clinicians do not turn away from the study of psychological trauma because they lack interest or even because they are unconvinced that its effects are real and devastating. Rather, she contends, it is because proximity to trauma brings into consciousness two existential truths – human vulnerability in the natural world and our capacity for evil.

Some of the earliest references to the effects of psychological trauma come from the 19th century, when both industrialization and modern psychiatry were in their infancy. At the time, railway cars were insubstantial, wooden structures that made train travel both uncomfortable and dangerous, due to the regular occurrence of railroad crashes. Before long, articles about a new condition called *railway spine* or *postconcussion syndrome*[5] began appearing in medical journals (e.g., Waller, 1861 as cited in Cohen & Quinter, 1996); the symptoms of which included sleep disturbances, nightmares involving train crashes, tinnitus, fear of railway travel, and chronic pain. Because symptoms were often reported by individuals who had no observable physical injury, the question arose as to whether or not any real harm had occurred. On one side of the debate were those who believed that railway spine had organic causes, while their opposition thought them to be purely psychological in origin (cited in Lamprecht & Sack, 2002; van der Kolk, Weisaeth, & van der Hart, 1996). The latter argument stigmatized affected individuals as either constitutionally weak or as dishonest in their attempts to defraud railway companies for compensation. A few years later Oppenheim (1889, cited in Weisaeth & Eitinger, 1991) relabelled the syndrome *traumatic neurosis.* Ostensibly, this is the first time the word trauma was applied in psychiatry.

It was during these debates about railway spine that some of the basic questions about the nature of psychological trauma began to form. Is it a medical disorder? If it is, is its cause physical or psychological? Does the trauma result from the event itself or from the individual's subjective experience of the event? Is the harm due to an inherent weakness in the individual? Nested within these questions are larger and more basic questions about the relationship between mind and body, between the self and the world

[5] In today's vernacular, these conditions might be diagnosed as *whiplash* or *soft tissue injury.*

that continue to resonate in the clinical trauma literature (Cohen & Quintner, 1996; van der Kolk, Weisaeth, & van der Hart, 1996).

A confounding issue in the debates about railway spine – especially when they involved women – was its relationship to *hysteria*. Hysteria, from the Greek word for womb (Anderson, Anderson, & Glanze, 1994), was a major focus of study in the late 19th century (Herman, 1992; van der Kolk, Weisaeth, & van der Hart, 1996). An exact definition of hysteria is difficult to pin down as the term was used in association with a long and varied list of maladies including neurological, respiratory, cardiac, and psychiatric problems (Marlowe, 2000). The length and diversity of associated symptoms led Micale (1989, p. 319) to muse that hysteria was "a dramatic medical metaphor for everything that men found to be mysterious or unmanageable in the opposite sex". Despite this, physicians of the time could not help but notice the similarities between the symptoms of railway spine and hysteria. This further complicated the debate about the origins of both conditions disorders and highlighted gender as an important factor in the study of psychological trauma.

By the late 19th century, interest in hysteria was at its peak in Europe. In their work at the Salpêtrière hospital in Paris, the French neurologist Jean-Martin Charcot and his student Joseph Babinski concluded that hysteria was psychogenic in origin because its physical symptoms could be induced and relieved through hypnosis (Herman 1992; van der Kolk, Weisaeth, & van der Hart, 1996; Weisaeth & Eitinger, 1991). This discovery provided an important connection between hysteria and another emerging phenomenon that Pierre Janet would later call *dissociation* (van der Kolk & van der Hart, 1989).

Janet, also a student of Charcot's, noticed that female patients went into states of consciousness when recalling troubling events from their past. This led him to propose that relationships exist among hysteria, dissociation, and the emotional distress associated with these past experiences. Janet hypothesized that psychological trauma results from an inability of an individual to integrate memories and emotions surrounding these events into narrative memory, rendering both the distressing memory and the attendant emotions dissociated from consciousness.

Working independently of Janet, Sigmund Freud and Joseph Breuer reached a similar conclusion about hysteria. Both groups of men also discovered that many of the

symptoms of hysteria would disappear if the traumatic memories were verbalized. Janet named his version of this process *psychological analysis*, while Freud later settled on the term *psychoanalysis* (Herman, 1992).

In a manuscript titled *The Aetiology of Hysteria*, Freud (1962, p. 203) wrote that, "at the bottom of every case of hysteria there are one or more occurrences of premature sexual experiences, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis". While this provided another vital link between traumatic childhood experiences and adult symptomology, Freud would later denounce this hypothesis and turn his attention to other interests.

Combat trauma

Another line of investigation in the study of psychological trauma grew out of the study of military men during wartimes. Meyers (1870) coined the term *soldiers' heart* to describe the extreme fatigue, dyspnea, palpitations, sweating, tremors, and fainting sometimes seen among soldiers involved in combat. A year later, Jacob Mendez Da Costa (1871) a surgeon in the American Civil War, elaborated on Meyer's work. Also known as *irritable heart*, *effort syndrome*, and *DaCosta's Syndrome*, Da Costa wrote about a syndrome that he thought was a purely biological response to the stress of battle (Birmes et al, 2003; Moreau & Zisook, 2002). His take was particularly valuable, because it provided an

> honorable solution for all parties who might be compromised by people breaking down under stress: The soldier preserved his self-respect, the doctor did not have to diagnose personal failure or desertion, and military authorities did not have to explain psychological breakdowns in previously brave soldiers, or bother with such troublesome issues such as cowardice, low unit morale, poor leadership, or the meaning of the war effort itself. (van der Kolk, Weisaeth, & van der Hart, 1996, p. 48)

Despite these advances, the study of trauma waned once again until World War I when thousands of soldiers - young men and teen-aged boys – repeatedly faced the threat of their own death and witnessed the brutal deaths of their comrades. In response, many of them "began to act like hysterical women. They screamed and wept uncontrollably. They froze and could not move. They became mute and unresponsive. They lost their

memory and the capacity to feel" (Herman, 1992, p. 20). The British military psychiatrist, Charles Samuel Myers (1915) used the term - *shell shock* - to describe this reaction, which he attributed to cerebral concussion caused by proximity to exploding shells. When Myers also observed the same symptoms in soldiers not directly engaged in battle he differentiated *shell concussion* (a neurological condition) from *shell shock*, a psychological response caused by exposure to the extreme conditions of war (Lamprecht & Sack, 2002).

Abram Kardiner (1941), an American psychiatrist who studied with Sigmund Freud in Vienna, employed psychoanalytic theory to explain what he called *war neurosis*. Kardiner noted that soldiers often had amnesia for the traumatic event that precipitated the war neurosis, while at the same time behaving as if they were still in the midst of it. He explained this combination of amnesia and physiological arousal as an attempt by the individual to protect their ego integrity. Although he recognized that many of the features of war neuroses were similar to those of hysteria, he was hesitant to link the two because of the stigma associated with the latter. He rationalizes this in the quote below:

> When the word 'hysterical' …is used, its social meaning is that the subject is a predatory individual, trying to get something for nothing. The victim of such neurosis is, therefore, without sympathy in court, and …without sympathy from his physicians, who often take… 'hysterical' to mean the individual is suffering from some persistent form of wickedness, perversity, or weakness of will. (Kardiner & Spiegel, 1947, p. 1).

Although the relationships among psychological trauma, war neurosis, and hysteria were still unclear at the end of World War I, they were collectively being referred to as *psychic trauma*, the cause of which was thought to be a non-specific neurological problem. Interest in trauma lapsed into another period of amnesia until new hostilities erupted in Europe and the Pacific a few years later when interest in the psychology of combat trauma began again in earnest (Herman, 1992; van der Kolk, Weisaeth, & van der Hart, 1996).

Alarmed by the high costs associated with psychiatric casualties during World War I, the US military began screening potential recruits to eliminate those who were psychologically unfit for the demands of combat (Marlowe, 2000). As the war progressed

however, it became clear that while some men may be more likely than others to develop psychological symptoms in battle, all men no matter how brave, had a *breaking point.* With this recognition, ideas about causation shifted away from the biological or characterological inadequacies of the individual to the role of the environment in psychological health and illness.

During this same time, the American psychiatrist Herbert Spiegel was in Tunisia, working on strategies to minimize psychiatric casualties. Spiegel (1944) concluded that the most important factor in a soldier's ability to cope with combat trauma was his relationships with members of his combat group. When these connections were weak or absent, the potential for psychological trauma was high. The risk was even higher when there was a lack of trust and/or communication between the combat group and its immediate leadership (Marlowe, 2000).

Later, Kardiner and Spiegel (1947) hypothesized that the strongest protection against the trauma of war was the quality of the relationships among an individual soldier, his immediate fighting unit, and their leader. This thinking led to the establishment of "front-line psychiatry" (van der Kolk, Weisaeth, & van der Hart, 1996, p. 58), the goals of which were proximity, immediacy, and expectancy. In an effort to limit the separation of traumatized soldiers from the protective effects of their fighting units, psychiatrists began working out of mobile army hospitals near the fronts of battle. Treatment was brief and focused on resolution of immediate problems, with the expectation that soldiers would return to their units as soon as they were able (Marlowe, 2000).

Posttraumatic stress disorder becomes a psychiatric diagnosis

The recognition that the social and physical environments could affect psychological health signalled a major shift in modern psychiatry. By the 1960s, psychoanalytic theory was in decline and new ideas from the social and behavioural sciences were infusing into the practice of medicine, where they crystallized into the concept of *stress*, as we understand it today. Working independently after the war, those working with Holocaust survivors (Krystal, 1968; Nathan, Eitinger, & Winnik, 1963); rape victims (Burgess & Holmstrom, 1974); battered children (Kempe & Kempe, 1978); and Vietnam veterans (Figley, 1978) developed discreet pockets of knowledge about the

effects of various types of psychological trauma. It was not until the 1970s however, that critical linkages were made among these bodies of work.

The impetus driving the integration of these seemingly disparate works was the groundswell of concern about the problems experienced by returning Vietnam War veterans. Energized by the human rights and anti-war sentiments of the previous decade, Vietnam veterans banded together to lobby the US federal government for compensation and rekindled interest in the effects of psychological trauma. Together these forces influenced the third revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980) in which both civilian (e.g., rape trauma syndrome, battered woman syndrome, abused child syndrome) and military trauma syndromes were subsumed under the diagnostic label of posttraumatic stress syndrome (PTSD). It is important to note here, that at the same time as the DSM-III PTSD work group was developing its ideas about the effects of trauma; unbeknownst to them another group was creating a diagnostic category for dissociative disorders (van der Kolk, 1994). Because the two groups had no awareness of each other's work (despite the centrality of trauma to both diagnoses), the initial formulations evolved in isolation of each other.

The Nature and Scope of Interpersonal Violence

Over the past two decades, I have come to appreciate that the effects of any traumatic event reflects a complex and dynamic interplay between a particular individual and the event itself. A one-time traumatic event in adulthood, like a natural disaster or a motor vehicle crash, typically has very different effects than the repeated trauma of childhood sexual abuse. Judith Herman (1992) believes that this is because trauma in adulthood affects "the structure of the personality already formed … [while] repeated trauma in childhood forms and deforms the personality" (p. 96).

The trauma of childhood sexual abuse results from violence, which Simpson (2007) defines as "the exercise of physical force so as to inflict injury on, or cause damage to, persons or property". Although the World Health Organization (WHO; 1996) agrees that violence causes harm through the use of force, it expands the notion in some key ways. Firstly, it recognizes that *threatening* the use of force or power against another is in itself a form of violence and secondly, it states that violence, as in the case of

depravation, can include acts of omission as well as those of commission. Most importantly, it acknowledges that violence or the threat of violence harms the whole person. With all of this in mind, the WHO (1996, p. 5) defines violence as

> [the] intentional use of physical force or power, threatened or actual, against one-self, another person, or against a community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or depravation.

In a later document, the WHO (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) identifies three types of violence – *self-directed*, *interpersonal*, and *collective*. As the term suggests, *self-directed violence* includes both suicidal and self-harm behaviours (e.g., thoughts of self-harm and suicide, deliberate self-injury, and all parasuicidal behaviour). Interpersonal violence is further divided into two sub-categories - *family and intimate partner violence* and *community violence*. Family and intimate partner violence involves family members and intimate partners, generally within the home, while community violence occurs outside of the home, between or among individuals who may or may not know each other. *Collective violence* differs from community violence in scale, in that it serves the social, political, or collective agendas of large, identifiable groups (e.g., political parties, religious sects, or terrorist organizations).

Krug and colleagues (2002) estimate that in the year 2000, 1.6 million individuals worldwide died as the result of violence, with the vast majority of those deaths being in low and middle-income countries. High-income countries, like Canada and the U. S., report less than 10% of the violence-related deaths that year. As troubling as the number of violence-related deaths, is what is called "not-fatal violence" (Krug et al, p. 11) – those acts of violence that result in injury but not death. The effects of these acts are impossible to measure in any comprehensive way and even our best estimates represent the proverbial "tip of the iceberg" (Krug et al, p. 36).

My intent here is not to review the epidemiological literature on interpersonal trauma, but rather to highlight the themes that are salient to this discussion.

Because epidemiological studies are blunt instruments, they provide only estimates of incidence and prevalence rates. In part, this is due to the kinds of problems inherent in any type of measurement. Problems of conceptualization, operationalization,

instrumentation, information collection strategies, and so on, all affect the nature, quality, and accuracy of the data that epidemiologists have as raw material. Despite these limitations, large, population-based, epidemiological studies provide the most reliable estimates about the nature, scope, and outcomes of interpersonal violence. One such study is the U.S. National Comorbidity Survey (NCS; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), which collected information through face-to-face interviews with a representative sample of 5,877 individuals, aged 15-54 years. Findings of the NCS reiterate a now familiar pattern of themes that is borne out by similar studies around the globe. The first of these themes is that traumatic events are much more common than was once believed. According to the NCS, 60.7% of the men and 51.2% of adult women report at least one traumatic event during their lifetime.

A second theme in the NCS results is the gender differential across the type of trauma experienced. Men more often report physical attacks, combat experience, and being threatened with a weapon, held captive, or kidnapped. Women, on the other hand, women report more rape, sexual molestation, childhood parental neglect, and childhood physical abuse.

The third theme in the NCS speaks to the effects of exposure to traumatic events. Using the clinical diagnosis of PTSD (American Psychological Association, 1994) as an index of severity, the authors found that women are twice as likely as men to develop PTSD following exposure to a traumatic event (10.4% vs. 5.0%). This last theme has been the focus of considerable interest in the trauma literature, with the central question being '*What makes females more vulnerable to PTSD than men?*' The answer seems to be that females – women and girls – more often develop PTSD because they experience higher rates of interpersonal trauma, that is, the type of trauma that most often causes PTSD. In the NCS for example, rape carried the highest conditional probability of developing PTSD in both genders (men 65% and women 45.9%).

What all of this tells us, is that violence is a common occurrence around the world, with girls and women most often being the victims of interpersonal violence – the type of violence that carries the highest risk for physical, emotional, psychological, and spiritual problems.

The Phenomenology of Psychological Trauma

At the centre of psychological trauma is the experience of intense fear, helplessness, and/or horror (American Psychiatric Association, 2000; Herman, 1992; Terr, 1990). Because it is by nature personal, victims of interpersonal violence also often experience intense shame and self-blame. Terrorized by what has happened to them, they are desperate for comfort. At the same time, full of self-loathing and doubt, they lack faith that others will respond to them. As one woman, a rape survivor, put it "...I was terrified of being with people and terrified of being alone" (Warshaw, 1988, p 68).

The perception of immediate danger precipitates an automatic, total-body response that Cannon (1939) called the *fight-or-flight* response. In an instant, hormones and neurotransmitters course into the bloodstream where they travel throughout the body, marshalling every cell into action (Saplosky, 2004; van der Kolk, McFarlane, & Weisaeth, 1996). As the danger subsides, the body returns to its normal state. When stress is severe or prolonged, the cumulative effects of stress-responsive hormones and neuromodulators can permanently change an individual, leaving them with alterations in consciousness, self-perceptions, beliefs, emotion, and ability to relate with others. Clinicians and researchers often describe these changes as *intrusion, avoidance, and hyperarousal.*

Intrusion is the recurrence of memories of trauma in the form of *flashbacks* and nightmares. "Traumatic memories lack verbal narrative and context; rather they are encoded in the form of vivid sensation and images" (Herman, 1992, p 38), which intrude on survivors' consciousness as flashbacks during waking states and as traumatic nightmares during sleep. Flashbacks are often elicited by reminders of the traumatic event (e.g., images, sounds, odours, tastes, and kinaesthetic sensations) and trigger a vivid real-time reliving of the trauma, accompanied by the full emotional force of the original event. Through *avoidance*, affected individuals attempt to evade all reminders of the traumatic event. Sometimes this means literally avoiding activities, places, or people associated with the traumatic experience, but may also generalize to a pervasive emotional numbing and the withdrawal from *all* usual activities and relationships. *Hyperarousal* is the experience of living in perpetual danger – these individuals startle easily, are irritable, sleep poorly, and have difficulties with concentration and memory. It is as if having confronted their mortality, it remains with them like a shadow.

Childhood Sexual Abuse

Although few argue that the sexual exploitation of children is morally wrong, legal definitions of what constitutes childhood sexual abuse vary across jurisdictions. There is general agreement however, that it involves (1) sexual acts with children who lack the emotional, maturational, and cognitive development to understand or to consent, and (2) "an 'abusive condition' such as coercion or a large age gap between participants, indicating lack of consensuality" (Finkelhor, 1994, p. 32). Abusive sexual behaviour may include voyeurism; sexual dialogue; fondling of the breasts or genitals; vaginal, anal, or oral intercourse; or enticing/forcing children to participate in pornography or prostitution (National Center for Victims of Crime, 1997). Based on 932 substantiated reports of sexual abuse involving both girls and boys, the *2003 Canadian Incidence Study of Reported Child Abuse and Neglect* (CIS-2003; Trocmé, MacLaurin, Fallon, Black, & Lajoie, 2005) reports the following frequencies of sexually abusive behaviours: voyeurism (1%); attempted penetration (4%); exhibitionism (6%); sexual talk (7%); penetration (7%); exploitation (7%); oral sex (11%); and fondling (55%).

All trauma (including childhood sexual abuse), involves human vulnerability – the susceptibility to wounding, of being unable to defend against or escape harm from others who are stronger and more powerful. Gro Harlem Brundtland (2002), Director-General of the WHO, paints a haunting picture when she says that for

> many people, staying out of harm's way is a matter of locking doors and windows and avoiding dangerous places. To others, escape is not possible. The threat of violence is behind [the door] – well-hidden from public view. (p. 14)

Sadly, the most frequent perpetrators of childhood sexual abuse are older, known, and trusted caregivers or other trusted authority figures in a child's life. Once again, the empirical research literature gives us a window into children's experience. Consider the following:

- In Canada, girls under the age of 18 were the victims in 79% of the 2,553 family related sexual assaults reported to police in 2001 (Statistics Canada, 2004).

- The *CIS-2003* (Trocmé et al, 2005) reported that in cases of substantiated sexual abuse by a relative, perpetrators were a relative other than parents (34%); stepfather (13%); biological father (9%); biological mother (5%). Non-relative perpetrators include child's friend or peer (15%); other acquaintance (9%); parent's boyfriend/girlfriend (5%); family friend (4%); stranger/unknown (3%); and babysitter (2%).
- The U. S. National Center of Child Abuse and Neglect confirms that nearly 1.5 million children in that country are mistreated each year and that 700,000 of these involve sexual, physical, and emotional abuse (Sedlack & Broadhurst, 1996).
- Among adults with histories of child abuse, approximately 21% report having been both physical and sexual maltreatment (Briere & Elliott, 2003).
- More than six out of ten of all rapes (61%) in the U.S. involve girls under eighteen, with 29% of all forcible rape occurring to girls younger than eleven (National Victims Center, 1993).
- In the *Commonwealth Fund Survey of the Health of Adolescent Girls* (Schoen et al, 1997), 12% of high school girls and 7% of girls in grades 5 through 8 reports having been sexually abused. Of the girls who experienced sexual abuse, 65% reported the abuse occurred more than once, 57% reported the abuser was a family member, and 53% reported the abuse occurred at home.

All of this should convince us that childhood sexual abuse does occur - in good families and trusted institutions; at all socioeconomic groups; and among all racial and ethnic groups. Affected individuals live among us as students, sports figures, clergy, entertainers, educators, police officers, judges, politicians, and health professionals. They are our friends and neighbours, our colleagues, and perhaps even members of our own family. Because many girls and women with histories of childhood sexual abuse assume a misplaced sense of responsibility for their abuse, they remain isolated and often haunted by soul-crushing guilt and shame.

The Health Effects of Childhood Sexual Abuse

The fact that women with histories of childhood sexual abuse are not readily identifiable does not mean that their lives are unaffected; a sizable proportion of them

live with a wide range of chronic behavioural, psychological, and physical problems that bring them into frequent contact with health professionals. In some settings they are labelled 'difficult patients' because of high service utilization; their numerous or vague complaints; and their inability/unwillingness to follow service providers' recommendations. Because health professionals do not routinely inquire about childhood sexual abuse, there remains under-recognition of its long-term effects, misdiagnoses of related health problems, and the lack of a sensitive, integrated treatment response (Felitti et al, 1998; Resnick, Acierno, Kilpatrick, & Kilpatrick, 1997; Schnurr & Green, 2004; Schnurr & Jankowski, 1999; Walker et al, 1999).

Women with histories of childhood sexual abuse utilize health services far beyond those directly related to the treatment of injury sustained during the traumatic event (Schnurr & Green, 2004). Adversity in childhood, including physical and sexual abuse, is associated with chronic pelvic pain (Reiter & Gambone, 1990); gastrointestinal disorders (Scarinci, McDonald-Haile, Bradley & Richter, 1994); intractable low back pain (Schofferman, Anderson, Hines, Smith, & Keane, 1993); and chronic headache (Felitti, 1991). Compared with women without histories of childhood trauma, those who report do report greater functional disability, more physical symptoms, more physician coded diagnoses, and more health risk behaviours, including driving while intoxicated, unsafe sex, and being obese (Walker et al, 1999). In one US health maintenance organization, Felitti and his colleagues (1998) found a direct relationship between the number of childhood adversity and the presence of adult diseases, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Survivors often attempt to cope with or avoid their distress through drug and alcohol use, self-mutilation, suicide, and disordered eating.

Several lines of research arrive at the conclusion that traumatized individuals have poorer physical and mental health and a lower health-related quality of life (Felitti et al, 1998; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Resnick et al, 1997; Schnurr & Green, 2004; Walker et al, 1999). Trauma, especially when it occurs early in life, is a major contributor in the development of psychiatric illness, particularly depression (Ballanger et al, 2004; Kendler, Karkowski, & Prescott, 1999). The fact that women with histories of childhood adversity have a 4-fold increased risk for depression,

leads some to endorse a model in which the causal pathways of PTSD and major depression following trauma are not independent (Breslau, Davis, Peterson, & Schultz, 2000; Stein & Kennedy, 2001).

Implications for health care providers

This growing body of evidence informs a growing consensus that using PTSD as the sole index for interpersonal trauma has limited utility. Judith Herman (1992) was among the first to challenge the sufficiency of the PTSD diagnostic construct, to capture the full range of human response to trauma. Based on her extensive clinical work with Holocaust survivors and survivors of sexual assault, she argues that as the nature, severity, and temporal characteristics of traumatic events vary so do individual responses. Herman believes that it is more accurate to conceptualize the human trauma response as a spectrum anchored at one end by an acute stress reaction that resolves on its own without treatment and on the other by "complex posttraumatic stress disorder [, with] … classic or simple" PTSD residing somewhere between the two (p 119).

In 1994, the diagnostic construct of 'complex' PTSD appeared in the DSM-IV (American Psychiatric Association, 1994) under the diagnostic label *Disorders of Extreme Stress not otherwise Specified* (DESNOS). The diagnostic criteria for DESNOS include: (1) alterations in affect regulation, which includes persistent depressed mood, self-destructive thoughts and behaviours, and problems with anger; (2) alterations in attention and consciousness, such as amnesias, flashbacks, dissociative episodes, and depersonalizations; (3) alterations in self-perception, including chronic guilt, self-blame, and shame; (4) alterations in relationship to others stemming from inability to trust and difficulty establishing and maintaining healthy personal boundaries; (5) somatization, which involves the expression of somatic symptoms on a somatic level for which no medical explanations can be found; and (6) alterations in systems of meaning.

These diagnostic distinctions are especially important in clinical settings because they orient health practitioners to the fact that they encounter individuals with histories of childhood sexual abuse everyday in their practices. Sometimes a practitioner will know that an individual has a history of abuse, but in most cases they will not. Given the intimacy and (often) invasiveness of procedures and treatments, it should be of surprise that for many survivors, health-serving environments are very frightening places. What

are simple, routine encounters for health professionals can be very distressing for survivors, because much about health-serving environments is reminiscent of the original trauma including, a sense of powerlessness, lack of control, invasion of personal boundaries, exposure, vulnerability, and pain. A touch - even when it is gentle - can trigger a flashback.

This chapter offered a brief overview of the uneasy relationship that mental health disciplines have historically had with the idea that events or experiences in the world can get 'into the body' and have long-term implications for an individual's physical and mental health. My intent was also to highlight the implications of gender with respect to the type of trauma that an individual is most likely to experience. As we saw in the NCS (Kessler et al, 1995), men are more often exposed to physical attacks, combat experience, and being threatened with a weapon, held captive, or kidnapped, while women are more vulnerable to interpersonal trauma (e.g., childhood sexual, physical and emotional abuse, parental neglect, adult sexual assault, and intimate partner violence). The latter – interpersonal violence – carries a high risk of PTSD and other health problems.

From their comprehensive review of the research regarding the epidemiology of sex differences in PTSD, Norris, Foster and Weisshaar (2002) offer the following conclusions: (1) Being female is a risk factor for PTSD; (2) exposure alone (i.e., amount and/or type of trauma) cannot account for women's increased risk of PTSD; (3) sex differences in PTSD are most evident from adolescence through middle age and less so early and late in life; and (4) social context may amplify or diminish the impact of trauma exposure. These authors suggest that biological, feminist-psychodynamic, and social-cognitive models hold promise for explaining these things further. What we can take from this is that childhood sexual abuse, like other types of psychological trauma is complex and a particular girl's response to it is affected by a number of interacting dynamics that have to do with her own make-up and coping abilities, and the presence and quality of social support throughout her life.

In the next chapter, I turn to pregnancy and birthing, both as social constructs and as a lived experience.

CHAPTER 3

SITUATING THE QUESTION: PREGNANCY AND BIRTHING

but who can tolerate the power of a woman
close to a child, riding our tides
into sand dunes of the public spaces.

Alicia Ostriker

With aim of enriching the ground for understanding the experience of pregnancy and birthing of women with histories of childhood sexual abuse, this chapter briefly examines of pregnancy and birthing first as social constructions and then as lived experiences. What knowledge discourses underpin North American healthcare institutions and maternity practices? How are women's bodies – in particular, pregnant and birthing bodies - viewed? What place do pregnant and birthing women occupy within these environments and practices? How do these larger social constructions and dynamics relate to women's embodied experience of pregnancy and birthing?

Each of these topics and questions opens up so many possibilities for discovery that doing them all justice requires much more attention than I can afford them here. Nonetheless, even touching on them briefly is important, if only to underscore Michel Foucault's (1972) critique of what he calls "unities of discourse" (p. 21). A discourse, according to Deborah Lupton (1999, p. 15) is "a bounded body of knowledge and associated practices". Foucault cautions against the propensity to view knowledge as static, monolithic, and unitary in nature, and of readily accepting any knowledge discourse without unravelling its history. He argues that understanding the archaeology of knowledge requires us to dig below the surface to uncover its origins, meanings, purposes, and effects. What historical, political, economic, and social dynamics support it and challenge it? What does it simultaneously enable and prevent, reveal and conceal?

Pregnancy and Birthing as Social Constructions

A Brief History of Modern Maternity Care

The earliest records of maternity come from prehistoric and Egyptian drawings of birthing women in sitting or squatting positions and from anthropological evidence suggesting that the earliest birth attendants were the birthing woman's female relatives. Later, written references are found in Hippocrates' description of "normal birth" (Drife,

2002, p. 311) in the 5th century B.C., in the Old Testament of the Bible, and in Soranus' (A.D. 98-138) obstetrical textbook, which was in use until the 16th century (Carr, n.d.). Although the invention of the printing press in Europe in 1450 allowed the production of a few pamphlets and textbooks about birthing practices, these had little impact because of their limited distribution and the low literacy rate. This meant that maternity care and birthing practices were the exclusive purview of traditional midwives until the 1700s. The knowledge that these female birth attendants employed was local in nature and developed through experience; the meanings they created around pregnancy and birthing practices were derived from whatever sources of information were available to them (e.g., oral history, folklore, religious doctrine, etc.).

Before going further, I would like to make a brief comment about language. Prior to the 1900s, the term obstetric - from the Latin obstare meaning 'to stand before' – referred to female birth attendants who stood in front of the woman to receive the baby. The Anglo Saxons later adopted the term 'midwyf' (mid – with, wyf – woman) (Drife, 2002). When 'midwifery' became a staple in the curricula of medical schools, it was again called obstetrics. Some suggest that this was done because the Latin derivative was somehow more scholarly.

Until well into the 1800s, the food supply remained unstable and malnutrition and rickets were common, the latter was responsible for high rates of pelvic deformity among childbearing women. A misshapen pelvis could obstruct a baby's passage through the birth canal, resulting in the long, difficult labours that contributed to high numbers of maternal and fetal deaths (Carr, n.d.).

According to Carr (n. d.) and Drife (2002), the Renaissance (*circa* 1300-1600) heralded many changes to birthing practices in Europe and Great Britain including the use of podalic version[6]; the invention, refinement, and increasing use of forceps to aid delivery; labour induction techniques; and nipple shields. During the 1600s, male midwives or *accoucheurs* gained popularity, particularly in France. One of these, Francois Mariceau (1637-1709) lent his name to a procedure for turning the infants head during a breech delivery (the *Mariceau-Smellie-Veit Manoeuvre*), although the procedure

[6] A manual maneuver to shift the position of an unborn baby to bring its feet to the opening of the cervix in order to facilitate a breech birth.

had been described several years earlier by another *accoucheur* by the name of Guillemeau. Mariceau is purportedly the first birth attendant to deliver women in bed (rather than squatting or on birthing stools) and to suture perineal tears. While this supine position facilitates suturing and other interventions, recent research tells us that it is associated with decreases in fetal heart rate during the birthing process, increased labour pain, and more forceps deliveries and episiotomies (Gupta, Hofmeyr, & Smyth, 2004). Although this change in practice may seem subtle, it was a harbinger of a fundamental shift away from the labouring woman as the centre of the birthing process, toward a focus on intervention.

At the dawn of the 1700s, most women birthed their babies at home in the care of traditional midwives. Throughout that century however, the conviction grew among the learned class that humankind could understand, predict, and control nature and in doing so, create a moral and just world (Best & Kellner, 1997). Inspired by Isaac Newton and with the machine as their logos, philosopher-scientists increasingly adopted the view of the cosmos as an orderly and lawful place to which reason is the key. Their project was to explicate the "real, ordered natural creation, independent of man but rationally knowable by man so that its properties could be discovered" (Hall, 1983, p. 358). The aim was to determine what Newton called "first cause" (p. 381). Knowledge of *first cause* would lead to "one incontestable system of universal principles" (1999, p. 61) that would affirm the glory of God and guide moral behavior. In that *Zeitgeist*, all knowledge save that based on rational thought and empirical science began to lose its credibility.

This period marked the beginning of a major turning point in our history that would leave no part of day-to-day life unaffected. It spawned transformations in technology, philosophy, patterns of work, law, education, and healthcare that propelled Western civilization into the modern era. Change was in the air and the effect on maternity care was to make it more interventionist in nature, which required a new and increasingly specialized type of knowledge (Carr, n.d.; Drife, 2002). For example, although a Swiss sow gelder, Jacob Nufer, purportedly preformed the first successful caesarean section on his wife in 1500, they became more common during the 1700s. Also in that century, midwifery schools were established in Paris, London, and Edinburgh, and William Smellie (1697-1763) opened the first British obstetrical ward.

Despite all that occurred in the previous centuries, one might argue that modern maternity care really originated in the late 17th century, with the recognition that "children are made by their parents, not sent, with all their imperfections on their head, from heaven" (Evans, 1875, as cited in Gardner, 1994, p. 53). This, according to Jean Talbot and her colleagues (n.d.), was a sharp turn away from pre-existing notions that placed the responsibility for pregnancy and its outcomes in the realms of the divine or the metaphysical. From then onward, pregnancy became the responsibility of "… individual agents, who are capable of making key decisions that influence the well-being of the fetus and the mother-to-be" (p.3). Embedded in this, are ideas about the body as owned (Rothman, 1989) and in need of management. These would become key themes in the modern medical discourse, which gradually usurped much of traditional Western maternity care and birthing practices. Within this discourse, the notion took hold that a pregnant woman can jeopardize her own health and that of her unborn baby through "wrong, risky behavior" (p. 3). This not only created the *possibility* for the emerging health disciplines to appropriate maternity care and birthing practices, it became their moral imperative to ensure the safe birth of a healthy infant.

As trust in the powers of reason and science grew through the 18th and 19th centuries, so did the number of hospitals, formally trained physicians and midwives, and hospital births - despite the fact that the maternal death rate was higher there than in home births. In the early 1800s, the maternal mortality rate in Great Britain was around 1 in 200 women who birthed at home; that number was 10 times higher in hospitals due to the frequent occurrence of puerperal fever (Louden, 1992, 2000). *Childbed fever*, as it was then called, declined dramatically with the advent of aseptic practices, which came about through the recognition of its cause being a microorganism (streptococcus) spread through hospitals on poorly cleaned instruments and on the hands of caregivers. By the end of that century, 'midwifery' was a compulsory subject in medical schools and the training of midwives was becoming more and more regulated. Traditional midwife-attended home births were on the decline among the well-to-do and instrument-assisted deliveries and the use of chloroform or ether (to reduce the pain of childbirth) were becoming more common (Drife, 2002).

During the 1900s and into this one, the ascendance of expert knowledge, the rise of health disciplines, and the increasing regulation of maternity care pushed traditional midwifery practice into the background. Where once they were the primary attendants at home births, they were now in direct competition with physicians who offered birthing care in hospitals, where they oversaw the practice of formally trained midwives. Many of the tensions that arose during that time among physicians, formally trained midwives, and traditional midwives continue to this day. This is particularly true in North America, where physician-attend hospital birth is the standard and midwifery practice is highly restricted by law and varies across jurisdictions (Beckett, 2005).

Managed pregnancies

Before the beginning of the last century, maternity care was limited to the birth itself. By the early 1900s, antenatal clinics were opening in Great Britain, the US, and Australia (Drife, 2002) and from that time forward, maternity care began soon after conception. The growing awareness of the role of microorganisms in disease and the public health movement brought about water filtration systems and regulations governing the milk supply, which reduced mortality rate, particularly among infants (Feldhusen, 2000). These things provided evidentiary support for what was becoming a growing focus of healthcare practitioners - prevention. The idea that disease, illness, and injury are preventable further emphasized the need to control the body in order to safeguard the health of the individual and society in general. This fuelled the need for professionals with expert knowledge to identify the presence of disease and to provide remedial treatment. One can imagine how in this climate, the notion of pregnancy as a pathological condition - something to be monitored and managed - might take hold.

Meanwhile, throughout the 20th century maternity care saw the increasing use of Morphine (an analgesic) together with Scopolamine (an amnesic) to induce *twilight sleep*, to reduce the pain of childbirth or at the very least, block it from memory (Feldhusen, 2000). The discovery of sulphonamides and later penicillin dramatically reduced infant and maternal deaths due to infection. By the middle of the last century, like most aspects of Western healthcare, maternity care was institutionalized and delivered in clinics and hospitals by health professionals. It is interesting to note here that the suffragette movement, commonly associated with first wave feminism, campaigned for the right of

all women to have access to "technological hospital birth, in the hope that it would constitute a positive step toward equality of the sexes through removing the cultural stereotypes of women as weak and dependent slaves to nature" (Davis-Floyd, 1992).

The pregnant and birthing body

In his book, *The Birth of the Clinic,* Foucault (2003) analyzes the discourse on medical perception (an assumption embedded in the rise of institutionalized medicine[7] in France), which began during the Enlightenment and gained momentum following the French Revolution (1789-1799). According to Foucault:

> The years preceding and immediately following the Revolution saw the birth of two great myths with opposing themes and polarities: the myth of a nationalized medical profession, organized like the clergy, and invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls; and the myth of the total disappearance of disease in an untroubled, dispassionate society restored to its original state of health. (p. 36)

With this move toward institutionalization of medicine in France and elsewhere in the Western world, came the construction of buildings and the implementation of policies and systems to operate them. Hospitals and clinics created the permanent, physical architecture that supported the proliferation of the medical discourse. Prior to this, physicians and a growing number of other health practitioners operated as independent agents whose practice was informed by personal knowledge acquired through formal education, experience, a relatively few printed materials, and/or one-to-one consultations with colleagues. Hospitals and clinics provided a place for the rapid accumulation and perpetuation of medical knowledge and its attendant practices.

A novel feature of hospitals and clinics was that they created a situation whereby *patients* were under continuous scrutiny; they were available to physicians' "observing" (Foucault, 2003, p. 131) or "clinical gaze" (p. 132) which could penetrate the body to discover its hidden truths[8]. This gaze, "the separating agent of truths" (p. 147), enables the diagnosing of problems and prescribing of treatment. It could not be acquired in

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[7] Although Foucault's treatise focuses on medicine, I would argue that much of what he says is applicable to all health disciplines.

[8] The 'gaze', in the practice of psychiatry, allowed physicians to see into the minds and souls of patients.

classrooms or from textbooks, but only through the prolonged clinical apprenticeships made possible by clinics and hospitals. As well as existing as a means to accrue knowledge, *the gaze* became an important aspect of medicine as a social practice. Under the clinical gaze, the "tangible space of the body … [opens] before the medicine of organs, sites, causes, before a clinic wholly ordered in accordance with pathological anatomy" (p.150). The human body is reduced to object, the individual's identity disappears, and they become *a case* or a diagnostic label. In our own time, we have seen the advent of technologies that literally allow clinicians to peer into the body (e.g., x-rays, ultrasound, scopes, etc.) and now, even into the human genome. According to Foucault (1977), all of this reflects the unique bent of modern institutions to create disciplined and docile bodies.

Implicit in the clinical gaze is a perceptiveness that enables the health professional to discern normal from abnormal, good from bad, health from disease and imbues the physician with incontestable power. As Nikolas Rose (1989) writes, because its aim is not merely to observe, but also to evaluate, "[the gaze] contains not only judgement about what is desirable, but an injunction as to a goal to be achieved. In doing so, the very notion of the 'normal' today awards power to scientific truth and expert authority" (p. 1989, p. 131).

The notion of the healthcare professional gazing on the objectified body reiterates "a Cartesian metaphysics in which the body is divisible into material (physical) matter – the empty vessel – and the immaterial (mental) substance: the mind or soul" (Goldberg, 2002, p. 447). In the hospital or clinic, the body becomes an object appropriated by healthcare professionals who interpret it as "*res extnsa* – a plenum of passive matter driven by mechanical forces" (Leder 1998, p. 119). According to Sally Gadow (1994)

> The body on this view is pure object, without interiority; every recess can be examined, in effect externalized. There is no intrinsic relationship between a pump and its owner, a scientific object and the persona as subject. The relation between body and person is a contingent one. The person thus has no inherent authority over her body. Logically it belongs to the expert; the brain to the neurologist, breasts to the gynecologist. (p. 298).

With respect to modern maternity care and its practices, some second wave feminist writers argue that the objectifying gaze of physicians and other healthcare professionals serves to undermine pregnant women's sense of ownership and authority over their bodies (e.g., Martin, 1987; Rich, 1986; Young, 1990). At its most extreme, this reduces the human heart to a pump, the brain to an elaborate circuit board, and the pregnant woman to a walking incubator. As Emily Martin (1987) points out, the conceptualization of pregnancy as (re)production is familiar in the medical discourse, with the body being a machine, women as unskilled labourers, and healthcare professionals the managers or supervisors.

Alternative/natural childbirth movement

Around the time that the post-World War II baby boom began in 1945, Ferdinand Lamaze (1956) and Grantly Dick-Read (1959) published books associated with what we now refer to as the *alternative* or *natural childbirth* movement. This was not a homogenous movement by any stretch of the imagination, it was "complex and [embraced] multiple meanings and means of performing reproductive rights activism" (Schriefer, n.d.). Dick-Read encouraged women to educate themselves about the birthing process so they could relax and feel safe. His notion of natural childbirth included childbirth without medicated or medical intervention and one in which the birth attendant's role is to provide support the woman to have "faith in the normal and natural outcome of childbirth" (p. 165). Lamaze[9] (1956) also encouraged unnmedicated labour and to that end, taught women to use a series of breathing patterns to help them cope with birthing pain.

Animated by the second wave of feminism, academics, childbirth educators, and writers (e.g., Davis-Floyd, 1992; Kitzinger, 2004; Martin, 1987; Oakley, 1980a, 1980b; Rich, 1986; and Rothman, 1982, 1989, 1996, among others) began to criticize medicalized childbirth. Although from different backgrounds and with different interests, there was a consensus that

> ... medical professionals, acting on the definition of childbirth as hazardous, intervene in what is essentially a natural process. Their

[9] The Lamaze approach is also referred to as *prepared childbirth*.

> management of birth decreases the control of the birthing woman, fails to improve physical and emotional outcomes of birth, and even alienates the woman from a potentially empowering experience. (Fox & Worts, 1999, p.327-8)

These contentions rest on the conviction that medicalized maternity practices reflect the power dynamics of patriarchy, which undermine women's sense of agency and personal control.

With the natural childbirth movement, came a new injunction for women to assume control over their bodies and to actively participate in their childbearing experience. As an example, Sheila Kitzinger (2004), an internationally known childbirth educator, has for decades been a vocal advocate of women's right to have the information they need to make informed choices about childbirth options. Without this information, she believes that women are alienated and disenfranchised from their bodies and their sexuality. She encourages women to trust their bodies and their instincts and, if they have no known health problems, to consider the option of a midwife attended home birth. The work of Kitzinger and others rekindled an interest in traditional midwifery in North America and created a bridge between midwifery practice and feminism.

In response to the growing interest in natural childbirth (at least among the middle class) books and prenatal classes proliferated and childbirth education became an expectation of maternity care (Wolf, 2003). Women and their partners were encouraged to educate themselves about childbirth and to negotiate written birthing plans with care providers. Husbands, partners, and/or other labour attendants were welcomed into to childbirth education classes where they learned to provide emotional support, comfort measures, and how to coach a woman through her labour.

North American hospitals changed their architecture to create more comfortable and home-like birthing rooms that permit women to give birth in the same bed in which they laboured. In the US, freestanding birthing centres were established to facilitate family-centred maternity care, which embraced pregnancy and birthing as woman-centred experiences that occur in the context of the extended family. In its recently published guidelines, the Public Health Agency of Canada (2000) describes family centred maternity and newborn care as

> … a complex, multidimensional, dynamic process of providing safe, skilled, and individualized care. It responds to the physical, emotional, and psychosocial needs of the woman and her family. In family-centred maternity and newborn care, pregnancy and birth are considered normal, healthy life events. As well, such care recognizes the significance of family support, participation, and choice … (p. 1.8)

The same document goes on to elaborate the principles of birth as a unique experience in a woman's life; the importance of mutual respect among women, their families, and their caregivers; the importance of choice; and the use judicious use of technology.

Has this changed maternity practice? Some like Naomi Wolf (2003) are sceptical that it has. In a book that both chronicles her own experience of pregnancy and birthing and discusses broader issues affecting childbirth in the United States, Wolf states that her desire as a pregnant woman was to

> … be informed about the experience in a way that was realistic, respectful, and honest. Most of all, I longed to be taught about the coming challenge by people who could share their expertise with me without an agenda of their own distorting what I was to expect of myself or what others were to expect of me. (p. 85-6)

She was discouraged when she heard that birthing plans "are not worth the paper they are written on" (p. 86) and are frequently passed around the nursing station for a laugh. Wolf describes her childbirth education classes as "sweet … like a fun, tender, silly rite of passage" (p. 89), but with a hidden agenda, which was that "[t]he pain of childbirth was clearly unendurable, and modern drug intervention was the only humane solution". When her labour began, Wolf felt completely unprepared for it. In the end, her daughter was born by caesarean because her labour did not progress. "Drugged and pinned" she writes, "that is what I remember of the birth" (p. 141).

In her epilogue, Wolf (2003) describes the birth of her son five years later. Although that pregnancy too ended with a caesarean section, Wolf has a different experience of it

> I hated the surgery the second time around - it was just as violent and invasive. But this time I was emboldened by an empowered caregiver

> ... I yielded to the C-section in a context of greater confidence, and found upon recovery that my spirit had suffered no incision.

What can we make of Wolf's experience? That medical intervention in birth is *bad* and *always* leaves women alienated from their birthing experiences, their bodies, and their sense of personal control? That a woman has only two choices – medicalized birth (which renders them feeling powerless and inadequate) or natural childbirth (which although painful, affords them a sense of control and accomplishment). What about those women who prepare for natural childbirth but in the end opt for medical intervention... have they failed? Even Wolf agrees that when she believed that her child's life was at stake, she did not question the need for medical intervention. In her place, I would do the same without hesitation.

Existing research indicates that while some women do feel disempowered and alienated by medicalized birth, many welcome these interventions and feel very satisfied with hospital deliveries (e.g., Davis-Floyd, 1996; Lazarus, 1994). A study by Bonnie Fox and Diana Wort (1999) of the University of Toronto, offers a finer grained analysis of what constitutes a positive birthing experience. They conclude that what is more important than whether or not a woman is the recipient of medical intervention, is the immediate context in which she gives birth. This includes the presence and involvement of a supportive partner, extended family, and friends; the quality and accessibility of pre- and postnatal resources; the nature of her relationships with professional caregivers; and the type of labour support she has. Reflecting the antiessentialist bent of what some (for example, Rebecca Walker) call third wave feminism, the American novelist Louise Erdrich (1995) writes

> In the first place, there are all sorts of labor and no 'correct' way to do it. I bow to the power and grandeur who insist on natural childbirth, but I find the pieties that often attend the process irritating. I am all for pain relief or caesareans when women want and need these procedures. (p. 42-3)

Pregnancy and birthing women represent but one aspect of a woman's life. Nonetheless, they are a time of monumental change, uncertainty, and complexity, a time when women and their families often turn to care providers for guidance and support. My hope is that even this brief survey of the discourses that underpin current maternity

practices will offer some insight into women's relationships with care providers and most especially, into their lived experience of pregnancy and birthing.

The Lived Experience of Pregnancy and Birthing

Pregnancy and birthing are part of an experience that transforms a woman into a mother (Bergum, 1989). On one level, it seems relatively simple and straightforward to describe the physical, emotional, psychological, and social changes that contribute to this transformation. On another level however, it is almost impossible for words to reach into its profound depths to grasp all of its many layers and complexities. The images of pregnancy and birthing familiar to us in North America are of women who are part of a smiling thirty-something couple; of dreamy-eyed women with hands resting on their pregnant bellies looking pensively into the distance; or brief glimpses of valiantly labouring women. While these images may tell us about *some* things about *some* women's experiences, they only hint at what might be going on beneath their glossy surfaces. It is what these images do not say, I think, that Naomi Wolf (2003) sought to explore in her book titled *Misconceptions: Truth, Lies, and the Unexpected on the Journey to Motherhood.* Wolf believes that these 'misconceptions' leave many women unprepared for what childbearing brings. Here is what some of the women she spoke with told her:

> *I wish someone had told me how unbelievably bloody and violent it would be... I wish someone could have let me know I would lose myself in the process of becoming a mother - and that I would need to mourn that self. I had no idea my emotions would be so extreme during pregnancy...I wish I had been prepared for the fact that nothing happened the way I hoped in the hospital. I wish I had been better prepared for the pain... No one prepared me for the fact that I would be on a forced march of exhaustion for months. I wish I had known that it would take a while to bond with her and that I would be okay...Nothing I ever felt for anyone compares with this; I am besotted-like an addict. I stare at her for hours.* (p. 2-3)

While it is true that we can never really know what an experience will be until we live it, perhaps the image of the Hindu goddess Kali more aptly represents the all-consuming nature and power of the transformation of woman to mother. The ferocious

looking Kali is typically depicted dancing, clutching a bloodied sword and a severed head in two of her four hands; she has a necklace of skulls strung around her neck. The halo around her head indicates her status as a goddess, as a transformer as well as a devourer.

> She is black, dark as the matrix, dark as the vortex, from which all creation comes and to which it returns. To her devotees, she is like a black sapphire; radiance shines through her blackness. She dances and laughs with abandon, intoxicated by the mystery she is. (Woodman & Dickson, 1996, p. 14)

The word *pregnant* is from the Latin word *praegnans – prae* meaning 'before' and *gnans* meaning 'being born' (Harper, 2001). In what follows, I explore women's experience of being transformed through their experience of being born as mothers.

Oh God, I'm pregnant! Uncertainty Begins

Whether the conception of a baby is carefully planned and orchestrated or the result of an *accident*, the confirmation of a pregnancy engenders surprise and a sense of unreality in most women. Below, Bergum (1989, p. 18) conveys Brenda's experience:

> *Actually, I wanted to wait another year, but I will be twenty-seven next week and if we want two children, I'd better get started. Tom really did not want to wait, so I agreed to have the IUD taken out with the hope that it would take a few months to get pregnant. But two weeks later I never got my period and I was shocked. I was shocked and I cried.*

Of her experience, Rebecca Walker (2007), the daughter of American writer and activist Alice Walker, writes:

> *And then the nurse said, Hello? And I said, Yes, I am here. Are you sure I am pregnant? And she said, Yes. And I said, Really? Are you sure? You are not going to call me back in two hours and say you made a mistake? She said, No. And I said, Well, how do you know? She sighed... I was in ecstatic bliss for about ninety seconds, and then it hit me: an avalanche of dread that took my breath away. Pregnant? A baby? What have I done? (p. 2-3)*

Naomi Wolf (2003) and her husband were at a wedding in Italy when, out-of-the-blue, another wedding guest – a complete stranger – told her that she was pregnant. Naomi's

first thought was that it was impossible; in fifteen years contraception had never failed her.

> *We looked at the results and gazed at each other – 'in wild surmise'. Then we reacted very differently. My husband needed to go for a run – and think; and I needed to sit still and not think. Male and female, after our first amazement, we reacted spontaneously, like different elements. (p. 15)*

A possible explanation of these reactions is that confirmation of her pregnancy launches a woman into a state of *liminality*. According to the late Carolyn Heilbrun (1999),

> the word 'limen' means 'threshold', and to be in a state of liminality is to be poised on uncertain ground, to be leaving one condition or country or self and entering upon another. But the most salient sign of liminality is its unsteadiness, its lack of clarity about exactly where one belongs and what one should be doing, or wants to be doing. (p. 3)

Although a particular woman's history and current circumstances will colour her reactions, on learning that she is pregnant a woman begins on a path that separates her from her life-as-she-knows-it and sends her into foreign territory. This new territory has no map or at least not a map specific enough to guide her as she journeys alone over new and unsteady ground.

(Un)prepared Childbirth

It is paradoxical that in an age where print media, reality television, movies, the internet, and experts abound with information about pregnancy and birthing, somehow it is not quite enough or the right kind of information.

> *Faced with something new and unclear, I turned to the experts: I went to the bookstore and began to read. Like pregnant women all over the country, and millions of women worldwide, I reached for 'What to Expect When You are Expecting'. I quickly developed a love-hate relationship with that book; I found it obfuscating and condescending – yet I needed it...Moreover, the reason it annoyed me was the same reason that, when in physical distress, I returned to it again and again – I and all the other*

expectant women in our millions. Why? Because, beyond the studies, science, statistics, and probabilities, it reassures. (Wolf, 2003, p. 23)

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Most of the instruction given to pregnant women is as chirpy and condescending as the usual run of maternity clothes ...- or its worse: pseudo-spiritual, misleading, silly, and even cruel...Women are strong, strong, terribly strong. We don't know how strong we are until we are pushing out our babies. We are too often treated like babies having babies when we should be in training, like acolytes, novices to high priesthood, like serious applicants to the space program. (Erdrich, 1995, p. 11-12)

In these quotes, the women seem to be alluding to the same thing – that the preparation for pregnancy, childbirth, and motherhood requires reassurance and support as much (or more) than it does information. Maybe it makes sense for a woman to feel unprepared in the face of a challenge of such enormity and consequence. Maybe none of us is ever ready for pregnancy and all that it means. Although the visible signs of pregnancy are evidence of a passage, the fundamental change – the transformation from woman to mother – is a unique, highly personal, and solitary one. Christina Baker Kline (1997) talks about this in her book *Child of Mine*, when she confides:

No one could have told me, when I found out I was pregnant for the first time, how overwhelming, exhilarating, and lonely becoming a mother would be. I thought I would handle it the way I handled other momentous events in my life, like planning my wedding or finding a job: I would read everything I could get my hands on about the subject, make lists, and talk to everyone I knew to find out how they had done it. It took me months to realize that this strategy, while practical, wasn't going to be enough. The lists I devised in my head – sign up for Lamaze classes, buy a crib and receiving blankets and diapers, paint the spare room – gave me a sense of control, but control wasn't necessarily what I needed. What I needed was confirmation that my experience was as complex and profound and terrifying as it was beginning to seem. (p.3)

This need compelled Kline to invite to stories from other women writers about their experience of pregnancy, birthing, and motherhood. Her intent was to create a virtual community of wisdom, compassion, and support for new mothers, one that rejects "the notion that certain feelings about becoming a mother are appropriate, and others are not" (p. 6).

Like Kline (1997), pregnant women and mothers of all ages gravitate to other women's stories of childbearing and motherhood. They do so for the information that these stories convey, but also to read between the lines for confirmation that they are not crazy or alone.

The Present Body

The antithesis of the mind-body dualism that arose during the Enlightenment is that mind and body are inexorably linked and that our subjective experience *of* and *in* the material, objective world (mind), is mediated through our bodies (Merleau Ponty, 1962). For most of us, this mind-body connectedness is so fundamental - like water to a fish – we simply take it for granted. That is, until our body changes in some way. Think about the last time you had a paper cut on the end of a finger, twisted your ankle, or were ill with the flu; when our bodies cannot function the way we have come to expect, they are suddenly front-and-centre in awareness until it heals and can resume its usual function. The body of an individual diagnosed with a life threatening disease or permanently disabled or disfigured, may never regain its former taken-for-granted status. Whether it is perceived by the individual as *untrustworthy*, *vulnerable*, *damaged*, or *dangerous*, it remains ever present, impinging on what they are able to 'do' in terms of behaviours or activities, but also on their sense of self, relationship with the world and other people, social roles, economic status etcetera.

During the 37 – 40 weeks of pregnancy, a woman's body undergoes a series of complex and dynamic changes orchestrated by the blueprint etched in each of her cells. Before her pregnancy is confirmed - particularly if it is a first or if, like Rosemary she has had difficulty conceiving - she may anxiously monitor her body for evidence of a growing baby.

> *At the beginning I was watching every little symptom, whether my breasts were tingling or whether I had to pee at night or if I felt nauseous. I was*

extremely nervous, wanting desperately to be pregnant. (Rosemary, cited in Morrison, 1987, p. 61)

Others, like Katherine (in Bergum, 1989, p. 32), talk about intuitively coming to know that they are pregnant,

It happened to be a particular cycle that we had had lots of good sex, and there was a change in my body, like I knew. I could feel the change in my breasts, a real change, and then I missed my period. That knowing made a real difference. We had gone out for dinner and had wine with everybody else, and just because I had that feeling in me, that hunch, then obviously I couldn't, I shouldn't be drinking now.

Once their pregnancy is confirmed, quickening (feeling the baby's move for first time) and ultrasound help to make it more real for them.

At first there were nudges like a knuckle through a feather quilt: these came after supper, little knocks, I wasn't sure it was you. Then one morning after breakfast you poked in an inch-and-a-half radius near my belly button: five or six times... (Gladys Hindmarch, 1976, p. 47)

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An oval emerged at length out of the chaos. 'There you can see the top of the fetus's skull,' she said without inflection. This after all, a routine part of her day, though to me it was the introduction of a lifetime. My heart started to race. (Wolf, 2003, p. 28)

The 30 or more pounds a woman gains during her pregnancy are concentrated in her torso, altering her shape and lowering her centre of gravity. With her increasing girth, the ease and fluidity that was a taken-for-granted aspect of her movements and activities are relinquished for planning and effort. Even getting out of chair has a method:

Moving to the edge of the rocking chair, I place one hand on the arm of the chair. I struggle to stand. My body heaves heavy...I push my belly out of the chair and upward, dragging the rest of my upper body along. (Van der Zalm, n.d.)

As her unborn baby grows inside of her, a woman may feel uncertain about where her body ends and the world begins. The face that peers back at her from the mirror is hers and yet it is not.

> *I see my face, but it is a face that is fleshier in the cheeks, skin darker on the cheekbones. I see a body that protrudes in front, blocking its own movement. Swollen breast, swollen fingers, swollen ankles. I strain to supplant the image in the mirror with the image of myself that I know, but that image eludes me. I see me, and I see my baby enclosed in a single body. (Van der Zalm, n.d.)*

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> *How could a being grow so vast! There was no part of me unstretched – even my toes were little clubs in my shoes! (Louise Erdrich, 1995, p. 41)*

Particularly in her ninth month, her size and discomfort may render a woman feeling feel that her body integrity is threatened, that she is vulnerable. Not only does she fear falling, but also about her ability to birth her baby.

> *My baby was so big at that point that I was in almost ceaseless discomfort. I had continual burning at the base of my esophogus. Two new blue veins had etched themselves on the underside of my right leg, and when I stood after sitting for too long, the right leg dragged heavily because of the blood that pooled there. My heart sometimes pounded with the effort of pumping all the extra blood, which produced a sinking, swooning sensation... With the loosening of my joints, I felt a weird disquieting sense of becoming prematurely undone, like a mandolin whose strings have loosened just before a performance. (Naomi Wolf, 2003, p. 129)*

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> *I look down onto my stomach, huge lap, feel my baby twist, and I can't figure out how I'll ever stretch wide enough. I fear I've made a ship inside a bottle. I'll have to break. I'm not me. I feel myself becoming less a person than a place, inhabited, a foreign land. (Louise Erdrich, 1995, p. 9)*

As with most things, women experience the physical changes of pregnancy differently. Some, like Cherry vehemently dislike their pregnant bodies:

> *I hated to be pregnant, ugh. I thought it was disgusting, and I still think so. I was so mad when someone told me I was big. I hated my big belly...*
>
> (Cited in Bondas & Eriksson, 2001, p. 829)

For others, like Gillian (Lemermeyer, 2007, p. 110) the physical changes of pregnancy represent the

> *... living of the rhythms of ... [her] body... Like a slow dance or a long walk, [they] began with intention in conception and ... [were] sustained by a gentle biological and emotional sway.*

Research into women's experience of the normal physical changes in pregnancy (e.g., Richardson, 1990; Rubin, 1984) suggests that women tend to view these changes as transient and unique to pregnancy. To her own eyes and those of others, her growing belly and the other bodily changes of pregnancy are the external manifestations of her changing identity. Whether she would say she enjoys or detests them, whether she feels enervated or inhabited, "[i]t is through her pregnant body that a woman comes to know herself as a mother" (Bergum, 1989. p. 53)".

Awakening to Self and Other

'The way of the mother'

While she was pregnant, the philosopher Iris Young (1990) noticed something curious when she felt her baby move inside of her for the first time – her subjective sense of her self, spilt. Her growing, moving baby was *her* and yet at the same time, *not her*. *Self* and *other* resided in her body simultaneously. As Young reflected, "[p]regnancy challenges the integration of my body experience by rendering fluid the boundary between what is within, myself, and what is outside, separate. I experience my insides as the space of another, yet my own body". In the moment that a woman experiences the presence of her growing baby a new moral relationship is forged, one guided by an ethic that Vangie Bergum (2007, p. 3) calls "the way of the mother".

The way of the mother, according to Bergum, is a woman's lived commitment to her child, which "... often catches ... [her] unaware ... It is a commitment to which she comes in her body and her heart, as well as her mind" (p. 7). At the same time as this

commitment is a turning to toward her child "as a person different from herself" (p. 5), it is also embodies a "renewed sense of self … [and a means through which she] comes to know herself in new ways" (p. 5). As Bergum explains, "[t]his turn toward the child and back to herself is a moral turn in which the woman asks the questions 'Who am I' and 'What should I do now?'" (p.5)

This awakening to another that is also an awakening to a new self is a defining moment in a woman's life. It involves deciding to have a child and how that will be lived; accepting the lifelong presence (and absence) of the child in one's life; the intense feelings of joy, love, and anguish associated with mothering; and the responsibility of caring for a child and all that entails (Bergum, 1989, 1997, 2007). Bergum believes that once a woman has embraced the way of the mother, it remains a part of her even if she miscarries, places her baby for adoption, or if she is estranged from her child through death or other circumstances.

> *It made you more thoughtful, it made you more introspective, it made you want more security... (Maggie, cited in Morrison, 1987, p.97)*
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> ~
>
> *My son opened up a new continent for me, a territory of emotions as big and inviting and perilous as Africa. I comprehend now the bottomless beauty of a child's innocence ... My love for my son extends automatically, reflexively to any child, allowing my feelings a large new freedom that I could never have foretold, allowing the lock off my gentleness. (Helen Winternitz, cited in Kline, 1997, p. 59)*
>
> ~
>
> *And I often wonder, if it had been given to me to know beforehand what I know now about motherhood – the swift and merciless loss of innocence, how you are transformed overnight from being someone's child to being someone's parent, handed summarily a love so incandescent and irrevocable that you stay awake twenty-four hours a day to protect all of the dark dangers out of left field – if I had known this beforehand, would I have agreed to have a child? (Amy Herrick, cited in Kline, 1997, p. 82)*

As much as that moment of awakening to her child is a generative one, it is also marks the death of the woman's self and life as it was. Immediately following the telephone call from the nurse telling her she was pregnant, Rebecca Walker (2007) looked out of her window and saw

> *A vulture falling from the sky in a perfect spiral. He was flapping the gliding, flapping then gliding as he descended, and I thought to myself: I will remember this moment and that vulture for the rest of my life. I thought to myself: That vulture is a sign. A part of me is dying. (p. 1)*

The dichotomy of that moment that contains birth and death, joy and pain, self and other is inherent in the way of the mother and relives itself over and over throughout a woman's life. As the American poet and musician David Meltzer (1981) says in the opening pages of his anthology of birth,

> The woman conceives. As a mother she is another person than the woman without child… Something grows into her life that never departs from it. She is a mother. She is and remains a mother even though her child dies, though all of her children die. For she at one time carried the child under her heart. (p. 3)

The way of the mother as a lived, relational ethic invigorates the intensity of a mother's bond with her child and her dedication to nurturing and protecting her child. In the same way that the woman's body stretches to accommodate her growing baby, the way of the mother leaves no dimension of her being unstretched (Erdrich, 1995). Although the experience of motherhood is one of great joy, the woman is continuously pulled in opposing directs as she cares for her child and her family, while at the same time trying to be her self.

> *I felt stoppered, paralyzed with guilt. I had actually taken her back to the nursery after the morning feeding because I desperately wanted to shower. (Elissa Schappell, cited in Kline, 1997, p. 28)*

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> *...I have to acknowledge to myself that I would not have chosen to have more children, that I was beginning to look to a time, not too far off, when I should again be free, no longer so physically tired, pursuing a more or*

less intellectual and creative life... Another child means postponing this for some years longer – and years at my age are significant, not to be tossed lightly away. (Adrienne Rich, 1986, p. 28)

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How many women are buried beneath their houses? How many startling minds, how many writers? This house is over two hundred years old. How many women lie stunned within its walls? It is a new phenomenon that so many women bear and raise children and do work in the outside world. (Louise Erdrich, 1995, p. 103-4)

It is an endeavour that is even more daunting when she lacks the necessary resources and support.

Observing and disciplining the body

Once committed to the way of the mother, the pregnant woman maintains a heightened awareness of her body; she focuses her energies on ensuring the safe birth of "the perfect baby" (Bondas & Eriksson, 2001, p. 828). In North America, most women receive prenatal care from a family physician, nurse practitioner, midwife, or obstetrician who monitors her body in order to assess her health and that of her developing baby. During these regularly scheduled appointments, she is likely to be weighed; the height of her uterus, her blood pressure, and the baby's heart rate measured; and the constituents of her urine and blood checked. Periodically she may have vaginal examinations, laboratory tests, and imaging procedures (e.g., ultrasound). If she is fortunate, her caregiver will spend some time discussing her concerns and offering emotional support.

Like Debbie below, most women, do not question their prenatal care or ask why a procedure or test is being done, even when they are unsure of its potential risks and benefits.

...I felt that the tests were mandatory ...I never questioned the tests because it seemed like standard procedure, and it didn't feel extraordinary ...it was like, I'm at eighteen weeks, and now we're doing this and this and this. (Cited in Rosenthal, 2006, p. 379)

In part, it is this new sense of responsibility for the safety of another that contributes to a heightened sense of vulnerability as she navigates the uncertainties of pregnancy.

This uncertainty makes her vigilant for anything that can instruct her about what constitutes a *normal* pregnancy and *healthy* fetal development, which she then relates to her changing body and to her baby's well-being.

> *These books and magazines create a standard of reality, an objective benchmark by which ... [women] can assess their skills and their progress. They tell you what is 'normal' – what to expect each month of the countdown to birth... The issues are clear-cut, and the message is plain: Don't panic, motherhood is manageable if you follow these simple rules. (Kline, 1997, p. 3)*

As her knowledge about pregnancy increases and her experience of being monitored as a pregnant body (read: object) accumulates, the woman gradually internalizes the task of monitoring her pregnant body as an object; something she owns and must manage.

> ***Worry, blame, and guilt***
>
> *Most of all, I worry over what I want to hold. I want perfection. Each day I pray another perfect cell to form. A million of them. I fear that my tears, my moods, my wretched weeping will not imprint on the baby's psyche. I fear repression, a stoic face shown to the world, will cause our child to hide emotions. I make too much of myself, expect too many favors, or not enough. (Louise Erdrich, 1995, p. 9)*

In an effort to support her growing baby, the pregnant woman alters her diet and takes vitamin supplements to ensure that her developing baby has all of the requisite nutrients. Those who are normally inactive may take up exercise, while those who usually participate in vigorous exercise or contact sports may scale back to decrease their risk of injury. Women conscientiously avoid substances or situations that may harm their babies or interfere with their health or development. While some women, seem to have a relaxed and trusting confidence that their body knows just what to do to create and birth a baby,

> *It requires no thought at all for me to form and fix a whole other person (Louise Erdrich, 1995, p. 8).*

Others harbour the anxiety about their ability to care for and protect their developing baby. A hint of anything untoward – whether an increase in one of the common

discomforts of pregnancy or something more serious – engenders fear, worry, guilt, and blame, by the woman herself and by well-meaning others. Underlying these responses is that the woman, through commission or omission, must have caused it.

> *When you're pregnant, the book said, it is wise to wear gloves when gardening in case you inadvertently brush up against any leavings of stray cats. Just an hour before I had been gardening and I had not been wearing gloves. I was instantly plunged into a state of the most frantic despair and gloom, certain that I had contracted this hidden germ[10]. (Amy Herrick, cited in Kline, 1997, p. 74)*

~

> *One relative, worried about my vomiting asked, 'What have you done to yourself?' A great-aunt remarked, meaning it kindly, and referring to my work schedule: 'Sensible eating and lots of rest – that will be a first for you!' My otherwise supportive mother announced, 'I have to talk to you about the fat in your diet'. I felt for the first time the experience of being addressed as a good or not-so-good vessel for someone else's well-being. (Wolf, 2003, p.61)*

~

> *Sonogram after sonogram. Sometimes a younger doctor joined the specialist to observe the procedure: 'This woman's baby is too small, lets take a look at why'...What had I done wrong? Was my body defective, unable to grow a strong enough placenta? I obsessed about the days I hadn't eaten enough, hadn't drunk enough milk. (Ericka Lutz, cited in Kline, 1997, p. 105)*

Through all of this - the constant monitoring of her body and vigilance to the ever-present potential for harm – from her own body and from the world at large, the dangers of the world remain in sharp focus for the pregnant woman.

Giving Birth

> *But who gives it? And to whom is it given? Certainly it doesn't feel like giving, which implies a flow, a gentle handing over, no coercion. But there*

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[10] Toxoplasmosis

is scant gentleness here, it's too strenuous, the belly like a knotted fist, squeezing, the heavy trudge of the heart, every muscle in the body tight and moving, as in a slow motion shot of a high-jump, the faceless body sailing up, turning, hanging for a moment in the air, and then – back to real time again – the plunge, the rush down, the result. Maybe the phrase was made by someone viewing the result only: in this case, the rows of babies to whom birth has occurred, lying like neat new packages in their expertly wrapped blankets, pink or blue, with their labels scotch-taped to their clear plastic cots, behind the plate glass window.

No one ever says giving death, *although they are in some ways the same, events, not things. And* <u>delivering</u>, *that act the doctor is generally believed to perform: who delivers what? Is it the mother who is delivered, like a prisoner being released? Surely not; nor is the child delivered to the mother like a letter through a slot. How can you be both a sender and a receiver at once? Was someone in bondage, is someone made free? Thus language, in it archaic tongues of something, yet one more thing, that needs to be re-named. (Margaret Atwood, 1982, p. 208-9)*

In her musings, Margaret Atwood shows us how some of the words we commonly use in relation to childbirth are euphemistic and convey very little about what the experience really means for the woman and her child, for all of us collectively. Atwood goes on to suggest that the problem with language is that we are both "stuck with" it and "stuck by" it (p. 226). Like the black bubbling tar in the tar sands exhibit at the Royal Ontario Museum, words are viscous and they adhere. We are "stuck with" them, because as the basic elements of language, they are all we have to express our ideas and to tell our stories. All words have their limits though, and even the very best ones convey only a portion of our intended meaning. What is more, we can also be "stuck by" words; they can weigh us down and suck us under like the prehistoric creatures who wandered too far into the tar ponds. Like those dinosaurs, words can fossilize and become irrelevant.

The problem with this of course, is that life moves on. Things are created, change, and disappear. Concepts, perspectives, and new knowledge gain prominence and then

fade into history, supplanted by new ones that reflect current experience, values, and different points of view, and different ways of knowing. If all we have are 'fossilized words' to describe a phenomenon, we create a dissonance between lived experience and language. Words and phrases like 'deliver' and 'give birth' are examples of such words because they do not come anywhere near to saying anything about women's experience of childbirth.

Labours of love

> **lāb' bour,** *n.* bodily or mental work, exertion, (~ **of love,** task one delights in or does for love of someone). (Simpson, 2007)

> **labour** [L, work], the time and the processes that occur during parturition from the beginning of cervical dilation to the delivery of the placenta. (Anderson, Anderson & Glanze, 1994)

Any way that you approach it, birthing a baby requires tremendous effort, uncertainty, and pain. Some women describe childbirth pain as the most excruciating they have ever felt and as we have heard, many who invest considerable effort into preparing themselves for it, find themselves caught 'unprepared' in the face of it. What is it that they have prepared for and what catches them by surprise?

Fear

A recent Swedish study by Carola Eriksson and her colleagues (2006) reiterates what many women already know, but may be hesitant to admit – the prospect of childbirth engenders feelings of fear. This study and the comments of other women not associated with it, offers us some insights into the breadth and depth of that fear and about the things that both help and hider women's efforts to face it. Some women experience fear related to childbirth long before they become pregnant, even as early as in their adolescence. Once pregnant, the women in Eriksson et al's study talked about feeling various levels of fear, from "a continuous feeling of dread" (p. 243) throughout pregnancy, to intermittent fear that increased as labour drew near. Naomi Wolf's (2003) experience mirrored the latter.

With a week to go, my fear over the impending birth was acute...Alternating with this sense of dread was a calm equally deep. I would lie in bed, on my side, with my hands on the baby, and feel drawn into a field of unbearable sweetness. (p. 130)

Furthermore, women tend to evaluate their level of fear in terms of their global self-perception. For example, one woman who thinks of herself as being "pretty tough and not at all a nervous person" (p. 244) was surprised by her fear, while another who described her self as "rather sensitive" and having "a low pain threshold" (p. 244) was not. Below, Gail Greiner talks about the 'monster' who plagued her life after the divorce of her parents when she eight and infused her life with worry.

When I was older the monster manifested itself in anxiety that I wouldn't get married, which turned into a worry that I wouldn't be able to get pregnant, to the fear that I would miscarry in the first trimester, to the fear that my baby would be born with some horrible malady. (Cited in Kline, 1997, p. 140)

Those women in the Eriksson et al study (2006) who reported having high levels of fear tended to evaluate themselves as being inferior to others.

Like most of us, women deal with childbirth related fear by avoidance, denial, "processing" it (Eriksson et al, 2006, p. 244); that is, by actively engaging in activities to help us face whatever it is we fear), and/or seeking help from others. Women in the study who relied heavily on evading their fear did so by avoiding thoughts of it, by keeping busy, or actively focussing on something other than their impending labours; some of these women opted to have an elective caesarean section.

I avoided looking at pictures or reading about deliveries. (Cited in Eriksson et al, 2006, p. 244)

~

For me there was only one choice: it had to be a caesarean section, otherwise I didn't know what I would do. (Cited in Eriksson et al, 2006, p. 244)

Those women who deal with fear by processing it, engage in activities on their own that they believed would help them manage the pain of labour (e.g., informing themselves

about what to expect and practicing relaxation and breathing techniques). Still other women seek support from partners, family and friends, and/or healthcare professionals.

> *Knowledge was an important part of it for me, but at least as important was relaxation and self-management (Cited in Eriksson et al, 2006, p. 244)*

~

> *Along with breathing and relaxation exercises and parent education, we learned to do our own prenatal exams. The same weigh-in and urine check as before, but the coaches took the measurements and used the Doppler stethoscopes to listen and count the baby's heartbeat. (Jessica Sabat, cited in Kline, 1997, p. 98)*

Some women find talking about childbirth related fears to be difficult, in part because it brings their fear into awareness, but also because they expect not to be taken seriously, to be dismissed out of hand, to be thought badly of, or because they think that no one can really help them anyway (Eriksson et al, 2006). Those who find it difficult to speak openly about their fears sometimes attempt to communicate their feelings subtly, with the hope that an understanding and interested caregiver will pick up on them and respond. Gillian Lemermeyer (2007) was fortunate that her midwives helped her to discover the root of her fear of having a caesarean section.

> *For me, delivering by caesarean section was the worst scenario (obviously not as grave as losing my child or my life) that I could imagine. However, as I considered what this might mean to me and read accounts of women who deeply regretted and resented giving birth in this way, I realized it was not necessarily the procedure itself that many women were depressed and angry about. It struck me that it was the process of getting to the caesarean section that caused me heartache for these women, and would have, I suspect, for me. These mothers described feeling ignored, overwhelmed, pressured, uninformed, and patronized by people they did not know well and did not have faith in. (p. 122-3)*

Eriksson and her colleagues (2006) believe that one reason that care providers do not ask women about their fears relates to a larger societal assumption that "pregnancy is

an especially happy and harmonious period that carries with it a strong confirmation of female identity and improved self confidence" (p. 246). Because pregnancy is 'supposed' to be a happy time, unfettered by worry, because birthing itself is relatively short lived, and because a healthy baby should make it all worth while, healthcare providers may ignore, minimize, or gloss over women's fears, which may inadvertently contribute to women feeling of isolated, unsupported, and unprepared for labour.

> *There was no openness when I came to the antenatal clinic, the midwife didn't understand what I was talking about, my fear was like nothing. (Cited in Eriksson et al, 2006, p. 245)*

> *It was just like a slap on the shoulder and you know; women have been having children forever and all that. (Cited in Eriksson et al, 2006, p. 244)*

Pain

Vangie Bergum (1989) writes of an encounter during which a woman, who had participated in one of her childbirth preparation classes, asked why Vangie had not told them about the pain of childbirth. Vangie was stunned because she believed she had. What had happened? Had the woman's attention lapsed, had she drifted off to sleep and missed that part of the class? That seems unlikely, given that learning to manage the pain of childbirth is a primary reason that women attend these classes. How could Vangie have spoken about something the woman was keenly interested and yet the woman had no recollection of it? Perhaps in the grip of her contractions the woman was so completely in her body that she temporarily lost access to her powers of recall. Whatever happened, this particular woman's experience is not unique.

> *Then we were in the car and speeding along in the dark and I literally thought I was going to die, The contractions were coming in waves and the pain was so intense and unbearable I couldn't do anything but scream and freak out and lose my mind when they hit...I couldn't believe that all human beings came here this way and that every single mother had to go through this. (Rebecca Walker, 2007, p. 176-7)*

It was like demonic possession, an out-of-control wild ride, during which I could only yelp, squeak, and groan. Thirty killer minutes later I began pushing...It hurt, really hurt – exponentially worse than the worst pain I'd ever experienced before – but far more than that, the exertion was wiping me out. (Jessica Sabat, cited in Kline, p. 100)

An ethnographic study by Carlton, Callister, and Stoneman (2005) offers some insight into the nature of birthing pain and how it influence a woman's choices about how to manage it. The authors observed 33 labouring women in three different US birthing units; for some of the women it was their first labour, others had birthed previously. On arriving on the units, the women indicated that they planned to have 'natural' childbirth (i.e., without medication) but during the course of their labours, accepted analgesia. The reasons offered for wanting natural childbirth were that it was seen as a 'rite of passage' into the community of women before them who had birthed babies without medication, wanting to be fully aware and present to the birthing experience, and concern about the potentially harmful effects medication might have on their babies.

The reasons the women gave for accepting analgesia were intense pain, length of labour, not knowing what to expect coupled with feelings of anxiety, feelings of lack of control and poor preparation, the inability to relax, and not feeling supported by the nurses. The women's feelings about having accepted medication ranged from disappointment through ambivalence to satisfaction; having a healthy baby displaced their concerns for themselves and salved their disappointment.

Like the women in the study described above, Rebecca Walker (2007) entered the hospital with the plan of having a natural childbirth. Her labour was long and painful, which led to her accepting – no, *insisting* – on having epidurally administered analgesia. Her birthing experience was further complicated when her baby's head got stuck under her pelvic bone, which slowed his descent for long enough that he began showing signs of distress.

At that point, time became a major issue. The nurse's machine was beeping and she kept putting the oxygen mask over my face and doctors started coming into the room to see what was going on... The baby would come out a little and then go back. He did that several times, until I was

completely exhausted and didn't think I could do it anymore. That was when I started saying, Just cut me open and get the baby...I was pushing so hard I thought the sides of my head were going to burst open. I was pushing so hard I thought I was going to knock myself unconscious. (p. 180)

In the moment before Rebecca would be wheeled to the operating theatre for a caesarean section, her baby's head popped free and he was born vaginally.

Most of the women in a study by Diana Fox and Bonnie Worts (1999) noted earlier, entered hospital wanting to have a natural childbirth but were also 'flexible' about the possibility of intervention. As one woman framed it,

Whatever happens is okay. I'd prefer to do it as naturally as possible, but I won't know 'til I get there (Bonnie, cited in Fox & Worts, p. 334).

When the women in the Fox and Worts study reflected on their actual birthing experience immediately afterward, they did not separate their own well-being from those of their infants. That is, if their baby was safe and healthy, whatever had happened was okay with them.

There's nothing wrong with him, so it's perfect for me. That's all I wanted. I didn't care how he came out". (Debra, cited in Fox & Worts, p. 334)

However, a few days later women whose babies remained healthy started to distinguish their infants' needs from their own. As they did so, 22 of the 40 women who participated in the study were angry or upset about some aspect of their childbirth experience. The reasons they gave for this included loss of control over what happened to them, distress about how medical intervention had affected their birthing experience (e.g., epidural had numbed all sensation), and anger that hospital personnel did not intervene soon enough or at all to manage their pain. On the other side of the coin, women who described positive birthing experiences offered the following reasons: absence of intervention, retention of a sense of control, absence of pain, tremendous support, a healthy baby, and an easy birth.

During her pregnancy Gillian Lemermeyer (2007), with the help of her midwives, "made peace" with the possibility that no matter how well prepared she was for a natural childbirth, her birthing experience might not go according to her plan. She came to this acceptance through her relationships with her caregivers.

I believe that it was the trust I placed in my midwives, and by extension the trust in my body that they fostered within me, that would have allowed me to come to terms with and accept as my own any manner of birth experience. My relationship with them was fully engaged...I did not feel that they would ignore or override what I knew I needed or wanted. If Joanna or Maureen suggested to me that I needed a caesarean section, I would have trusted that they were fulfilling my trust in them by taking drastic measures to protect me and my baby. (p. 123)

Support

Vangie Bergum (1997) writes that the pain of childbirth is the pain of separation, the physical separation of mother and baby, as well as the final separation of the woman from her life before motherhood. The moment of her child's birth is, without a doubt, another defining moment in a woman's life. It is why the memories of days and hours that precede and follow that moment remain salient and relevant for years following (Simkin, 1991). Whatever type of birth she plans and actually has, whether it is short or long, complicated or not, there is overwhelming evidence that the key component of a positive birthing experience for women is the presence and quality of support.

In everyday usage, the word *support* means to *hold up*, to *keep from falling or sinking*, or *to give strength or courage* (Simpson, 2007). According to a recent Cochrane Review (Hodnett, Gates, Hofmeyer, & Sakala, 2007), support during childbirth includes emotional support, information, and comfort measures. The review concludes that women who have continuous support during labour are more likely to have a spontaneous vaginal delivery, report satisfaction with her birth experience, and are less likely to require analgesia. What is more, childbirth support showed greater benefit when the provider was not a hospital staff person and when it began early in labour, and in settings in which epidural analgesia was not routinely available.

The birth of a mother

Although childbirth is an arduous task, like many of life's challenges Adrienne Rich (1986) believes that it holds great opportunity for personal discovery:

> The majority of women, literate or illiterate, come to childbirth as a charged discrete happening: mysterious, sometimes polluted, often

> magical, as torture rack or as 'peak experience'. Rarely has it been viewed as one way of knowing and coming to terms with our bodies, of discovering our physical and psychic resources. (p. 157)

In fact, many women gain a sense of personal mastery from birthing their babies. Although they acknowledge the process as painful, the pain itself does not define their experience. Like the protagonist in the hero's journey, birthing pain can be transformative. The mythological hero figure leaves their home and all that is familiar to them to embark on a quest that takes them into an unknown and dangerous realm where the rules and limits are unknown to them. While in this state of liminality (Heilbrun, 1999), the hero's mettle is tested at every turn. The final takes them to their lowest point, where they must face a huge challenge alone. It is as they traverse through the darkest part of the journey that the final separation occurs between their known self and world to a qualitatively new self and a new world.

> *I don't think one should focus on the pain, that women should have to experience pain. But in the pain there is an experience of being inward and involved in feeling the pain – not enjoying it but taking hold, enduring, or whatever you do to handle it – and knowing that it is going to produce a child. This is what it is, not to focus on the pain, but to see what the pain does to you, how it changes you. (Christine, cited in Bergum 1989, p. 65-6).*

~

> *Rocking, breathing, groaning, mouthing circles of distress, laughing, whistling pounding, wavering, digging pulling, pushing – labor is the most involuntary work we do. My body gallops with these rhythms. I'm along for the ride, at times in control and at others dragged along as if foot-caught in a stirrup. I don't have much to do at first but breathe, accept ice chips, make jokes – in fear and pain my family makes jokes, that's how we deal with what we can't change, how we show our courage. (Louise Erdrich, 1995, p.42)*

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My mother is quiet, serious, and concentrating, but she catches me watching her, and she smiles too. 'You did so well Gill. I am so proud', she says. I have the strangest, most unexpected impulse to bang my hands on the shower wall and to laugh out loud. It occurs to me that in this moment of birth, the history of millions of birthing women before me, the future of my baby and my mothering and all of the mothering that would come after me, were all present with me and within me. (Gillian Lemermeyer, 2007, p. 118-9)

In the next chapter, I turn to what has been written about this life-challenging experience and women with a history of childhood sexual abuse.

CHAPTER 4

REVIEW OF THE LITERATURE ON CHILDHOOD SEXUAL ABUSE, PREGNANCY, AND BIRTHING

The published literature on pregnancy and birthing among women with histories of childhood sexual abuse is surprisingly small, given that these experiences are pivotal in women's lives and have important implications for their health and the health of their babies. For the purpose of this brief review, I have divided the literature that does exist is into three broad categories - theoretical, research-based, and autobiographical.

Theoretical Literature

This literature, written by nurses, midwives, childbirth educators, and physicians and draws on clinical experience and reviews of the literature. These writings focus on the observed and anticipated problems that women with histories of sexual abuse often encounter during pregnancy and childbirth (Aldcroft, 2001; Courtois & Courtois-Riley, 1992; Gutteridge, 2000; Hobbins, 2004; Howarth, 1995; Leeners, Richter-Appelt, Imthurn, & Rath, 2006; Prescott, 2003; Roussillon, 1998; Seng & Hassinger, 1998; Seng & Petersen, 1995; Simkin, 1996; Simpkins, 2005; Smith, 1998a, 1998b, 1998c; Tidy, 1996; Waymire, 1997; Weinstein & Verny, 2004; Wescott, 1991). In them, the authors highlight the potential for abused women to dislike their bodies and the attention their bodies receive during pregnancy. They also speak of the women's feelings of lack of control, problems with trust, sense of violation by healthcare practices, and re-traumatization by childbirth-related experiences. Recommendations for sensitive maternity care include routine screening of all women for a history of childhood sexual abuse; emphasis on the importance of rapport, trust, and interdisciplinary collaboration; careful explanation and minimization of invasive procedures; and the development of a individualized birth plans to facilitate women feeling supported and in control.

In this literature, I also include a recent book by Penny Simkin and Phyllis Klaus (2004) titled *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women.* Based on their extensive clinical experience as a Physical Therapist/childbirth educator and Social Worker respectively, Simkin and Klaus provide in-depth information about the long-term effects of childhood sexual abuse and its implications for pregnancy and birthing. This book comprehensively describes many

of the common issues and problems that women with histories of childhood abuse encounter during pregnancy and childbirth, as well as specific strategies for addressing these difficulties. For example, some women who become pregnant unintentionally or who consider themselves unable to provide loving parental care may see pregnancy as a punishment or (re)victimization. Others completely deny or reject their pregnancies or are severely debilitated by some of the common discomforts of pregnancy. Simkin and Klaus believe that unresolved emotional and psychological problems related to past sexual abuse may contribute to "hyperemesis gravidarum (severe, constant vomiting), pregnancy-related hypertension, unexplained bleeding, prematurity or post-maturity" (p. 36). What can be even more confusing for both a woman and her caregivers is if she has not conscious memory of abuse but has strong, response to aspects of her care (Note: This was the case for Christine, whose story appeared in the opening pages of this text.).

The authors explain that women with histories of childhood sexual abuse often have fears, anxieties, phobias, or nightmares related to their unborn babies, interventions or procedures (e.g., palpation, vaginal examinations, blood draws, etc.), or impending labour. One commonly expressed fear is that their baby may be the 'wrong gender' (i.e., some fear that girls are more vulnerable than boys to being abuse, while others worry that a male-child may grow up to be an abuser). A few women get pregnant, not because they want to be mothers, but to prove that they are 'normal' or to demonstrate that they are completely unaffected by traumatic events in their past. For still other women, pregnancy is one of the most positive and affirming experiences of their lives.

Choosing a maternity care provider can be a difficult task for women with abuse histories. Some have strong preferences about a practitioner's gender, interpersonal style, philosophy, and/or about the environment they work in. Other women avoid regular antenatal care altogether and only seek attention in emergency situations. They do so because they know that routine care involves physical examinations and questions about their psychosocial history, sexual history, and life-style habits. On the other hand, women who have avoided healthcare providers for most of their lives may begin having regular care for the sake of their babies' health. A proportion of women may even become highly dependant on caregivers and demanding of a great deal of attention.

Frequently one of the biggest questions a woman with an abuse history faces is whether of not to disclose her abuse history to her care provider. Some fear that if they do, they will be labelled as 'bad' or 'defective'. Unfortunately this fear is not ungrounded as practitioners who know very little about the effects of trauma and may completely ignore the information, minimize it, or assume that the woman has severe emotional or psychological problems. Throughout the book Simkin and Klaus stress the importance of clear communication between women and their healthcare providers, particularly the need for practitioners to attend carefully to what women say and convey nonverbally.

The issue of control is often a big one for women sexually abused as children and it may loom even bigger when they are pregnant. As Simkin and Klaus explain, concerns about control may involve any or all of the following: "1) control over what is done to the woman by the staff and her own support people; 2) control over what her own body does; [and] 3) control over her behavioral reactions or responses..." (p. 74-5). Many pregnant women (regardless of their abuse histories) attempt to increase their sense of control by investing a great deal of energy in educating themselves about all aspects of pregnancy and childbirth through reading, internet research, and childbirth education classes. Still others engage doulas or trained support people.

Because practitioners typically have more power in the healthcare relationship, they are seen as authority figures. This dynamic may cause some women with histories of childhood abuse to be wary and mistrustful - particularly if their abuser(s) was a loved and trusted authority figure. Depending on a variety of factors women might respond by becoming very passive, by dissociating, or being openly hostile. A caregiver who has no understanding about the potential effects of sexual abuse may be completely confused and feel hurt, defensive, or angry.

Labour and birthing can be particularly challenging for women with histories of sexual abuse. According to Simkin and Klaus, some of these challenges are intrinsic to the processes of labour and birthing (e.g., uncertainty about when it will start, how long it will last, how much it will hurt, and how well the woman will manage the pain and fatigue). Extrinsic challenges include highly technical clinical environments; unfamiliar, uniformed care providers (some of whom may wear masks); invasive procedures; and being tied to a bed with various tubes, wires, and other devices. As well, the authors note

that comments like - 'Open your legs', 'Relax your bottom', 'This will only hurt a little' or 'Relax and it won't hurt so much' – may be reminiscent of past abuse and can engender acute anxiety or even trigger a trauma response.

Simkin and Klaus's book is accessibly written and contain information appropriate for both healthcare providers and lay individuals alike.

Another theoretical article by Kathleen Kendall-Tackett (1998) discusses the potential implications of childhood sexual abuse for women's breastfeeding experience. Kendall-Tackett suggests that PTSD symptoms, flashbacks of the abuse, feelings of powerlessness and anxiety, emotional distress, avoidance behaviours, dissociation, and interpersonal difficulties can all negatively affect breastfeeding. The author makes recommendations about educating and supporting women to make breastfeeding a more comfortable and satisfying experience.

Research-Based Literature

The second broad type of literature is comprised of research reports on various topics related to pregnancy and birthing among women with histories of childhood sexual abuse. In an early and often cited, retrospective survey, Jacobs (1992) compared pregnancy and birthing experiences of women with abuse histories with those of women who were not abused. He reported that women with histories of childhood sexual abuse were pregnant at a younger age, had longer labours, longer pregnancies, higher birth weight babies, more pregnancy terminations, more medical problems, and higher levels of stress. While admitting that his study is small and preliminary, he attributed his findings to stress-activated emotional and biochemical mechanisms.

Elaine Westerlund's (1992) doctoral research – which was eventually published in a book titled *Women's Sexuality After Childhood Incest* - employed a combination of interviews and questionnaires to explore women's lives after incest, with particular attention to all dimensions of their sexuality. In it, Westerlund reports that over half of the women she spoke with expressed negative feelings and attitudes toward the physical changes of puberty. The women often associated aspects of their developing reproductive capacity with the incest, leaving them with global feelings of anxiety, shame, and confusion about their bodies. Some of the women viewed normal functions like menstruation as evidence of loss of control or as a betrayal by their bodies.

Decisions about whether or not to bear children were often painful and full of anguish for the women. Some worried "that they would be 'overprotective', that they would 'abandon' or 'fail to protect' their children, that they would be 'inappropriate', 'seductive', 'harmful' or 'abusive' (emotionally, physically, and/or sexually" (p. 57). Others held deep-seated beliefs that they were so damaged or abnormal themselves, that they questioned their ability to have a normal child. Westerlund states that 9% (about 3 or 4) of the 43 women in her study told her that they wanted to be single or adoptive parents because they did not want a man to be involved in their children's lives. One woman spoke of her desire to have only sons, because she believed they would be less vulnerable to abuse.

Twenty-five (just under half) of the women Westerlund spoke with had been pregnant one or more times. Most of these women told her that pregnancy brought up a mixture of feelings related to their past abuse. Some felt "taken over by another" (p. 57) which reminded them of the incest, while others felt shame because pregnancy was evidence of their "badness" (p. 57). A few of the women were uncomfortable with the attention to their pregnant bodies and resulted in their feeling exposed and vulnerable.

While they were pregnant, the women's attitudes and behaviours toward sexual activity changed. Some were repulsed by their partners or by any thoughts of intercourse. Four or five of the women feared that sexual activity might be harmful to their unborn babies and one said, "[d]uring the first couple of months I had irrational fears about harming the baby by intercourse because it seemed 'incestuous' to have my husband's penis so close to the baby" (p. 58). Another woman in the study associated her birthing experience with forced intercourse and yet another talked about hating her pregnant body because she had no control over what it was doing. Another woman said that she felt "betrayed again" (p. 58) by her body when she needed to have a caesarean section.

Most of the women who had biological children (80%) nursed their babies. A woman, who decided not to, said that she was "repulsed" (p. 58) at the idea of having "something attached" (p. 59) to her breast. Two women discontinued nursing because their larger, milk-filled breasts made them feel self-conscious; two others said they felt very uncomfortable nursing as it left them with the sense that their bodies were no longer

their own. Other women who chose not to nurse said that it was too confusing for them to have both their babies and their husbands touching their breasts.

A common fear among one third of the women who did nurse, was that their bodies would "betray" (p. 59) them by becoming aroused when their babies suckled. As one explains, "If I had gotten aroused, I'm sure I would have felt like an incest offender" (p. 59). Several of the women who nursed successfully said they were surprised at their ability to do so; one woman who had problems nursing, judged herself as "inadequate" or "abnormal".

Sadly, only three of the women in the study who had biological children, described their experiences of pregnancy, birthing, and nursing as positive. Women who did find the experiences positive, described them as an "affirmation of normalcy" and as having given them "a sense of power" as women.

In her phenomenological study, Jenny Parratt (1993) found that although childbirth did trigger abuse memories for some women, the most important issues tended to be around privacy, control, touch, and having an individualized approach to intrapartum care. In a phenomenological study not specific to pregnancy, Lori Kondora (1993) revealed that the interactions that women with histories of childhood sexual abuse have with caregivers is very meaningful to them. When their care is respectful and compassionate, the women see themselves more positively through their caregiver's eyes and begin to redefine themselves as worthy. This in turn, helps them to be more compassionate and caring toward themselves.

Using an ethnographic approach, Naomi Rhodes and Sally Hutchinson (1994) explored labour experiences of childhood sexual abuse survivors and identified four distinct labour styles *fighting*, *taking control*, *surrendering*, and *retreat*. Although women without abuse histories may demonstrate similar behaviours, the authors believe they are not as extreme. These four labour styles are not mutually exclusive (i.e., a woman may demonstrate more than one of them in the course of her labour) and may serve as a useful heuristic to guide caregivers' understanding of a woman's needs.

The first of these styles, *fighting*, is characterized by a very long labour that often leads to the use of forceps or vacuum extraction or even a caesarean section. Rhodes and Hutchinson describe it as a panic response that arises from the woman's interpretation of

labour as an attack on her body; this style of labour is an effort to resist those sensations. According to the authors,

> [w]hen a sexual abuse survivor becomes fully dilated, progress in pushing may be particularly difficult because she misdirects her pushing energy to the upper part of her body. She tenses her vaginal muscles, raises her buttocks off the bed, and arches her back and neck. (p. 216)

A second labour style, *taking control*, involves attitudes and actions motivated by the woman's fear of being out of control. Unlike *fighting*, *taking control* may or may not inhibit labour. The woman who exhibits this style may appear either well-informed and organized or desperate; she may assert her desire to participate in her care decisions pleasantly but firmly or she may be demanding and aggressive. If caregivers do not respond positively to her, this woman will often seek alternative care providers. When a woman takes control of her labour in a positive way, she does so by carefully preparing herself to work effectively with her contractions, which Rhodes and Hutchinson believe is ultimately the most effective labour style for any woman.

The authors' third identified labour style is *surrender*, which manifests as total submission to the process of labour and to the requests of her caregivers. "[T]he woman may appear to be outgoing and uninhibited. She may open her legs without any apparent concern about her vulnerability and for personal privacy, and the caregiver may get the sense that anything will be allowed". Although caregivers may see her as a 'good patient', the woman's behaviour may be a sign of dissociation, feelings of helplessness, denial, or emotional numbing.

Rhodes and Hutchinson's fourth labour style is *retreating*. This woman is the classic stoic. She makes no verbalizations or indications of being in pain and may appear emotionally flat or vacant. A midwife recalls one woman who exhibited this style:

> She labored and had the baby but was completely spaced out through it. She never said anything through the whole labor. She was just one of those people who you think are wonderful in labor except they weren't there. (p. 218).

Vickie Waymire (1995) attributes the title of her phenomenological study of childbirth among women with abuse histories, *Haunted Birth,* to Merleau-Ponty's

observation that some experiences are so significant that "they 'haunt' the present. The haunting metaphor is paralleled by the cultural association of incest with secrecy, skeletons in the closet or ghosts of the past" (p. 57). The themes that Waymire identified as explicating the meanings and practices of the women in her study are – the knowing body, seeking connection, and striving for safety.

Through her interviews with both women with histories of child sexual abuse and maternity care providers, Burian (1995) discovered that the women are often reluctant to disclose their history because they did not want it noted on their medical record. The women also spoke of avoiding prenatal visits if they triggered flashbacks of their abuse. Maintaining control was of paramount importance to these women; some of them did so by being assertive or even aggressive, while others tended to be very passive or to dissociate.

In her unpublished doctoral dissertation, Linda Hyle (1995) found that a history of childhood sexual abuse among low-income women correlates with poor prenatal psychosocial adaptation, drug use, and difficulties in the postpartum period (e.g., lack of attachment, discontinuity of infant care, and physical abuse and neglect). Hyle also notes that a history of sexual abuse made a small but significant contribution to the birth of low birth weight infants, which she believes is mediated through health risk behaviours (e.g., maternal smoking, alcohol and drug use, inadequate prenatal care, poor maternal weight gain) and psychosocial factors.

A Norwegian study by Hilde Grimstad and her colleagues found a positive relationship between childhood physical and sexual abuse and smoking and alcohol use during pregnancy (Grimstad, Backe, Jacobsen, & Schei, 1998). Later, Grimstad and Schei (1999) determined that women with histories of childhood abuse were not more likely to have low birth weight babies, but did have more health complaints during pregnancy and more non-scheduled contacts with care providers.

Sharon Lee (2001) used semi-structured interviews in her doctoral research to explore how recovery from childhood sexual abuse relates to childbearing. She found that the women's childbearing experience is influenced by their ability to tolerate strong affect and to find positive meaning in their experience. Many of the women in the study viewed labour and birthing as rites of passage into recovery. Childbearing brought them

face-to-face with memories of their past and made them re-evaluate family relationships and the meaning of safety.

In her doctoral research through the University of British Columbia, Becky Palmer (2005) identified 'protecting the inner child' as the core process used by women with sexual abuse histories, to navigate their childbearing experiences. The women actively worked to be the best mothers they could despite '(over) protecting the self' and '(over) protecting their child'. They were more successful if they had the support of their healthcare providers; conversely, a lack of support was often re-traumatizing.

In Germany, Leeners, Neumaier-Wagner, Quarg, & Rath (2006) found that 12% of women presenting for obstetrical care at a university hospital reported a history of childhood sexual abuse. These women also described having experienced other types of abuse in childhood and as adults. The authors recommend assessing all pregnant women for abuse and referring women with histories of abuse for mental health services.

Antepartum, intrapartum, and postpartum depression are also topics of interest for researchers. Based on case studies of four women, Buist and Barnette (1995) conclude that women with histories of childhood abuse have low self-esteem, increased levels of anxiety, and poor relationships with their own mothers and their baby's father, all of which contribute to postpartum depression. Later Buist (1998) assessed 56 women admitted to hospital with postpartum depression for a history of childhood abuse – 28 of the women reported sexual abuse and 9 reported physical/emotional abuse. Using instruments to measure social support, adjustment, and parental bonding, Buist found significant difficulties in the mother-infant relationships among all of the abused women; women with histories of sexual abuse also scored higher on measures of depression and anxiety.

In a chart audit of 309 women seen for obstetrical care, Farber, Herbert, and Reviere (1996) determined that women with histories of childhood sexual and physical abuse more often express suicidal thoughts during pregnancy. Sexually abused women (but not those who had been physically abused) were more likely to have attempted suicide prior to becoming pregnancy. In a study by Mary Benedict and colleagues (1999), 37% of women attending two, university hospital-based prenatal clinics in Baltimore reported a history of child sexual abuse. These women were significantly more likely

than a comparison group to be depressed during pregnancy, to report more negative life events, and to experience physical and verbal abuse before and during pregnancy. Other work by Kathie Records and Michael Rice (2007) found that fully one-third of women receiving prenatal care had clinically significant depressive symptoms in their third trimester of pregnancy. The women described these symptoms as brief, intermittent, and situational. In this study, lifetime abuse did not contribute to depressive symptoms, although relationship dissatisfaction/ conflict, lack of social support, and gravida did.

A topic of recent and growing interest in this type of literature is the relationship of PTSD to pregnancy and childbirth. Based on a large Michigan dataset that included both perinatal and mental health data, Julia Records et al (2001) found, that after controlling for demographic and psychosocial factors, women with PTSD were more likely to have ectopic pregnancies, spontaneous abortions, hyperemesis, preterm contractions, and excessive fetal growth. In this report and elsewhere Seng and collaborators (Seng, 2002; Seng, Low, Sparbel, & Killion, 2004; Seng, Low, Ben-Ami, & Liberzon, 2005) hypothesize that these problems are mediated through PTSD induced behavioural (e.g., disordered eating, high-risk sexual behaviour, substance abuse) and neuroendocrine (e.g., cortisol, vasopressin, and oxytocin) alterations. In Hawaii, Leslie Morland's group (2007) also found correlations between PTSD in pregnant women and increased rates of health-risk behaviours (e.g., alcohol and drug use, smoking, poor prenatal care, and abnormal maternal weight (>40 pounds).

Lev-Wiesel and Daphna-Tekoa (2007) compared the severity of PTSD and depression in pregnant women with histories of childhood sexual abuse with those of women who had experienced other traumas or no trauma. As predicted, the researchers found higher levels of PTSD symptomology among the women with histories of childhood sexual abuse. They did not however detect differences in depression between the two groups.

Using a large US Medicaid database, Cook and her group (2004) estimated the prevalence of PTSD among pregnant women to be 7.7%. These same women were five times more likely to have a major depressive disorder during pregnancy and more than three times more likely to be diagnosed with generalized anxiety disorder than women without PTSD. The women with PTSD reported multiple lifetime traumas and recent

difficulties in their primary relationships. Rogal and colleagues (2007) report similar findings. They demonstrated significant associations between a diagnosis of PTSD and substance use, panic disorder, major and minor depression and prior preterm delivery.

Employing narrative analysis, Seng, Sparbel, Low, and Killion (2002) interviewed women who had histories of childhood sexual abuse and met diagnostic criteria for PTSD, with the aim of learn what constitutes optimal maternity care for these women. From the interviews, the researchers identified three groups, each group having unique care needs. The first group are women who are far along in their healing and require caregivers to act as *collaborative allies*. Such caregivers are knowledgeable, egalitarian, and interested in fostering a woman's overall well-being. A second group of women do not feel safe in the world and need caregivers to act as *compassionate authority figures*. Because compassionate authority figures understand the dynamics of PTSD and the (often) associated health risk behaviours, they are non-judgemental in their assessments, make appropriate referrals to mental health services, and follow-up with the women. The third group of women identified by the researchers were not ready to address their abuse and required a caregiver who is a *therapeutic mentor* (i.e., someone to respond therapeutically to signs of distress, to provide information, and to act as a role model).

A related topic of research looks at the birthing process itself as a traumatic event. From her review, Ayers (2004) concludes that although as many as 10% of women have severe traumatic responses to their birthing experience, only about 1% - 2% develop PTSD. Factors that predict birthing-related PTSD are low social support during labour and method of delivery. With respect to the latter, Ryding and colleagues (Ryding, Wijma, & Wijma, 1998a, 1998b) found instrument-assisted deliveries to be the most stressful, followed by emergency caesarean sections, normal vaginal delivery, and finally elective caesarean sections. At two days and 4 weeks postpartum, women who had instrument-assisted deliveries demonstrated the highest residual fear of childbirth.

In other work, Fischer, Astbury, and Smith (1997) report that the number of obstetrical interventions is not associated with depressed mood and lower self-esteem in the postpartum period, but method of delivery is. When the postpartum moods of women who had spontaneous vaginal deliveries, instrument-assisted deliveries, and caesarean sections were compared, those who had vaginal deliveries had the most positive moods,

those who delivered by caesarean section had the most depressed mood, and those who had instrument-assisted deliveries fell somewhere between the other two groups.

A qualitative study by Ayers, Eagle, & Waring (2006) reports that birthing-related PTSD affected women's physical well-being, mood, behaviour, social interactions, and attitudes toward childbirth for years afterwards. The women also spoke of the prolonged negative impact that their birthing experience had on their relationships with their partners, including increased conflict, blame, and sexual problems.

Autobiographical Accounts

The third and smallest type of literature is women's first-person accounts of pregnancy and birthing. One of the first to be published was written by Anna Rose (1992), the mother of two sons who has a history of childhood emotional, physical, and sexual abuse. Her first pregnancy and labour were particularly difficult because she did not understand much about what was happening for her and none of her caregivers offered her the information, guidance, or understanding that she needed. Her membranes ruptured prematurely and when contractions did not start, her labour was induced. She describes that birthing experience as "19 hours of hard labour, absolutely exhausting and unmanageable". As well as physical pain, she felt panicky and out of control. For her second pregnancy, she found a caring midwife who assisted her to birth at home. Anna Rose says that she wrote the article because she felt strongly that healthcare practitioners must be sensitized to the needs of women like her.

Anna Rose's piece encouraged other women to publish their stories in childbirth-oriented publications. These include Heather Henderson and Deborah Lipp (1992); Christine (1994) - whose story I recounted earlier; Ellen Phoenix (1996); and Khadj Rouf (1999). The woman's poignant stories tell of the challenges and joys they experience during pregnancy, childbirth, and motherhood. Unfortunately many of them lacked adequate support from partners, family, friends, and healthcare providers. Often the women did not understand what was happening for them and did not know how to ask for help. The women also write about how pregnancy and birthing taught them about their own strengths and opened the doors for healing.

Once again, we are left with a sense of the complexity of childhood sexual abuse and how, for some women, its legacies insinuate themselves into the experience of

pregnancy and birthing. As I step back to take stock of where I am in this inquiry, I have an image of having called a number of individuals to join me around a table to consider the question I posed back in Chapter 1 – *What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?* I have adjourned this meeting, because the question has both personal and professional significance for me. It is also one that I want to bring to the attention of other health professionals. To this point, the voices in this conversation have predominantly been those of academics, writers, researchers, and clinicians, offering their perspectives on childhood sexual abuse and pregnancy and birthing. These have been interesting to me and have created a context for understanding these experiences as social constructions and as lived experiences.

Given all of this, can I say that I now understand the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse? Yes … well maybe …, not really. Although I am well into a process of seeking and exploration, where I find myself now is immersed in a topic. A topic, according to Simpson (2007), is a "theme for discussion" or a "subject of conversation or discourse". Topics can bring us to the periphery of an experience, they can help us to circle around an experience, but they do not take us inside of the experience. Getting inside of an experience, understanding the subjective nature of an experience can only come from those who have actually lived it. Theirs' are the only voices that can tell me – us – what an experience is really like.

In the next chapter – one that I have titled *Methodology* – I describe how I intend to continue on in this journey of inquiry and my rational for choosing this particular path.

CHAPTER 5

METHODOLOGY

> ... only in a dialogical encounter with what is not understood, with what is alien, with what makes a claim upon us, can we open ourselves to risking and testing our preconceptions and prejudices (R. J. Bernstein)

This interpretive inquiry addresses the question: *What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?* Its aim is the creation of a descriptively rich and evocative text that gives voice to that experience and offers an understanding of the diverse and complex meanings embedded therein.

According to van Manen (1997, p. 2), "there exists a certain dialectic between question and method". The word *dialectic*, from the Greek word *dialegein*, means *to converse* (Audi, 1999, p.232). What van Manen seems to be suggesting, is that the research question and the approach taken to address it, inform each other. They speak *to* and *about* each other through the researcher's epistemological and ontological orientations. My intent in this chapter is to provide an overview of the philosophical and methodological traditions that inform this study, as well as to describe the methods I used in its conduct.

I begin broadly with a discussion of the assumptions about knowledge and knowledge creation that are foundational to the qualitative paradigm (Guba, 1990). Here I make reference to the work of a few key individuals who shaped the human science movement that began in late 19th and early 20th century Germany and elaborate on the nature of understanding (*Verstehen)* and interpretation, which are central to that movement. I then go on to talk about interpretivism as one "epistemological stance" (Schwandt, 2000, p. 189) within the qualitative paradigm. In the final section, I describe the methods I employed in this project to come to an understanding of the experience of pregnancy and birthing of women with histories of childhood sexual abuse.

Qualitative Research Paradigm

In the very broadest terms, there are two knowledge development paradigms - quantitative and qualitative. The word *quantitative*, from the Latin *quantits*, asks '*how much?'* or '*how great?'*, while the term *qualitative* (Latin, *qualitatem*) queries '*of what kind?'* (Simpson, 2007). Each appeared at a particular moment in history and evolved in

response to a myriad of interacting social, cultural, political, and philosophical epistemological influences. Both of these knowledge paradigms cut across topics of interest, fields of study and disciplines. They also rest on different philosophical foundations, employ different methodological practices, and draw from different literatures (Denizen & Lincoln, 2000).

Thomas Kuhn (1962) first introduced the concept of *paradigm* in his treatise on the revolutionary nature of science, which challenged long-held beliefs about how scientific knowledge advances. Kuhn, a physicist, was particularly interested in the way the nature of scientific truth changes over time. The prevailing belief was that science progresses in an orderly and cumulative manner, with new knowledge building on existing knowledge until the ultimate truth about a phenomenon becomes apparent.

This proved contrary to Kuhn's reading of historic scientific texts. Rather, he concluded that science advances as a result of periodic revolutions in knowledge development. These occur when existing knowledge cannot account for what is observed in the world. Resolution of the crisis comes when a new paradigm emerges that can account for all existing data (Stajduhar, Balneaves, & Thorne, 2001). In the wake of these tumultuous periods, is a relative calm during which scientists within a discipline adopt the new paradigm and discard knowledge developed under the previous one. Kuhn's (1962) ideas rippled throughout the scientific community, with much of the discussion fixing on what he meant by his use of the term paradigm.

For Egon Guba (1990) a paradigm is "a basic set of beliefs that guides actions" (p.17). He contends that comprehension of any knowledge paradigm begins with the answers to three basic questions about its ontology, epistemology, and methodology. Guba frames these questions as: What is the nature of reality (the *knowable*)? What is the relationship between the *knower* and the *knowable*? How should the *knower* acquire knowledge? In the next section, I consider these questions in relation to the qualitative paradigm.

What is the nature of reality (the knowable)?

Wilhelm Dilthey (1988) was among the first to argue that the natural sciences are fundamentally different in character and purpose from the human sciences. His project was to establish a theoretical and methodological foundation for the human sciences (e.g.

history, law, literary criticism) that was distinct from those of the natural sciences (e.g. physics, chemistry). While the latter is concerned with explanation, causation, and prediction of phenomena in the natural world, the former orients toward "mind, thoughts, consciousness, values, feelings, emotions, actions, and purposes, which find their objectification in languages, beliefs, arts and institutions" (van Manen, 1997, p. 3). Dilthey objected to the use of the reductionistic and de-contextualized methods employed in the natural sciences to human phenomena. He believed that the proper aim of human science inquiry is interpretation and understanding (*Verstehen*) of human experience.

Dilthey, building on Friedrich Schleirmacher's (1768 – 1834) ideas about hermeneutics, developed a philosophy of method for the human sciences (Mallery, Hurwitz, & Duffy, 1987; van Manen, 1997). This method, which Dilthey described as a *hermeneutic circle*, holds that

> … in order to understand the part (the specific sentence, utterance, or act), the inquirer must grasp the whole (the complex of intentions, beliefs, and desires or the text, institutional context, practice, form of life, language, game, and so on) and vice versa. (Schwandt et al, 2000, p. 193)

Although the qualitative paradigm is not a unitary phenomenon, proponents typically regard human behaviour as being inherently meaningful, endeavour to understand human experience as it is lived, and acknowledge the importance of human subjectivity in knowledge development (Schwandt, 2000). While this does not deny the existence of a material world, it assumes

> … that reality as we know it is construed intrasubjectively and intersubjectively through the meanings and understandings garnered from our social world. There can be no understanding without interpretation. We are always embedded in the lifeworld of language and sociohistorical understanding without recourse to some outside point of view, or Archimedean standpoint from which to gain objectivity on a world that is external to us. (Angen, 2000, p. 385).

What is knowable within the qualitative paradigm then, is not a singular, immutable truth about a phenomenon of interest. Rather, because many truths exist, knowledge development is the continuous process of (re)negotiating our understandings of them.

What is the relationship between the 'knower' and the' knowable'?

With respect to Guba's second question, the qualitative paradigm claims an integral relationship between the *knower* and *what is known*. Because human understanding is intersubjective and bound by history, culture, and language, it is impossible to separate our selves from what we know (Angen, 2000).

This stands in contrast to Edmond Husserl's (1962) notion of *phenomenological reduction* or *epoche*. Husserl, in response to a call to turn to things themselves (*Zu den Sachen*) (Husserl, 1911/1980, cited in van Manen, 1997, p. 31), aimed for a deeper understanding of the essential nature of phenomena in the lifeworld. Through epoche, he believed that it is possible for an individual to suspend their subjectivity, leaving them with the original data of consciousness. In this state of pure consciousness or *transcendental subjectivity*, Husserl thought that the essence (*eidos*) of phenomena in the lifeworld could be directly apprehended (Paley, 1998).

In contrast, Husserl's student, Martin Heidegger (1962), denied the possibility of *epoche*. Rather, he contended that understanding and interpretation are mediated by a foreknowledge or sensitivity that is a product of an individual's experience of *being-in-the-world* (*Dasein*). Heidegger believed that epoche precludes the possibility of understanding all together and that a vital aspect of being-in-the-world is the capacity to perceive the everyday world pre-reflectively. Stated differently, our experience in-the-world shapes our understanding of it. This pre-reflective understanding remains largely outside of our conscious awareness and yet enables us to immediately grasp a situation and respond appropriately to it.

For example, through my-being-in-the-world, I have come to understand the nature and character of 'door', such that when I approach one - whether it is the familiar door to my home or one I that have never seen before - I do not consciously have to think about what it is or what to expect of it. All doors are movable barriers that separate physical spaces. When I encounter one, I disengage the mechanical device (or devices) that hold it closed, open it, and then walk through into the adjoining space. Alternatively, I may pause briefly for an electronic sensor system to open the door for me. These pre-reflective understandings of the world are always incomplete because being-in-the-world (i.e., lived experience) is both contextually situated and finite. Returning to my door

example, if I lived in prehistoric times, before humans constructed shelters, I would not have the same pre-reflective understanding of 'door'.

Heidegger's (1962) approach to knowing supplanted Dilthey's notion of the hermeneutic circle as method, offering instead a "more fundamental ontological hermeneutic circle, which leads from existential understanding situated in a world to a self-conscious interpretive stance" (Mallery et al, 1987). This 'self-consciousness' however, cannot transcend being-in-the-world. In other words, while we can reflect on our foreknowledge, perceptions, and experience, we can never completely extricate our self from the limitations that being human places on our capacity to understand the world.

Similarly, Hans-Georg Gadamer (1970) maintained that understanding is a condition of being human and not a method or a rule-bound procedure. For Gadamer, understanding *is* interpretation, not

> an isolated activity of human beings but a basic structure of our experience of life. We are always taking something as something. That is the primordial giveness of our world orientation, and we cannot reduce it to anything simpler or more immediate. (p. 87)

Gadamer wrote that because every "finite present" (1975, p. 302) is situated, it is also limited. He used the metaphor of a horizon to conceptualize - "the range of vision that includes everything that can be seen from a particular vantage point" (1975, p. 302). This horizon is our frame of reference for understanding the world and reflects our own particular experience of being, which in turn, is influenced by our history, culture, and language. Gadamer believed that an individual's horizon (understanding) can be extended "through exposure to others' discourses and linguistically encoded cultural traditions because their horizons convey views and values that place one's own horizons in relief" (Mallery et al, 1987).

This notion of understanding as a fusion of horizons is reminiscent of the Hegelian (1830/1971) idea that every new achievement in knowledge results from the dialectical resolution of more basic and antithetical concepts. Applied to the research process, it suggests that the meaning of a phenomenon does not exist solely in participant's subjective experience or in the researcher's pre-understanding of the phenomenon of interest. Rather, new understandings of phenomena emerge through

dialectical engagement as the horizons of the participant and researcher fuse. Says Gadamer (1975, p. 368),

> [d]ialectic as the art of conducting a conversation, it is also the art of seeing things in the unity of an aspect (sunoran eis hen eidos) i.e. it is the art of the formulation of concepts as the working out of the common meaning.

For Gadamer, meaning does not reside as objective facts that exist in isolation, set apart from human experience. Instead, meaning is our subjective lived experience, derived through communal participation in everyday activities of language and culture (Geanellos, 1998). An inevitable by-product of situated human experience is the development of biases or prejudices - preformed conceptualizations of the world. These prejudices serve as the "forestructure[s] or preconditions of knowledge, in that [they determine] what we may find intelligible in any given situation" (Thompson, 1990, p. 241).

This suggests that all researchers approach disciplined inquiry with prejudices about the phenomenon of interest; without them, there would be no basis for even formulating a research question. The fact that a question is even asked at all, the way it is framed, and the manner in which the researcher addresses it, all reflect the researcher's prejudiced view of the world (horizon). Because all knowing is situated knowing, it is through the process of disciplined inquiry that researchers open themselves to alternative views of the phenomenon of interest. Through this process, a new horizon emerges at the interface between the situated experience of the participants and the "interpretative scheme used by the scholar" (Thompson, 1990, p. 255). In written accounts of the inquiry process, whether scientific reports or descriptive texts, the researcher explicates how their horizon has expanded as the result of the research process.

The claim that *knowing* is a subjective experience does not infer that truth is also subjective. In *Being and Time* (1962), Heidegger refers to truth – *aletheia* – as disclosedness or unconcealment. He does not offer this as a definition, but rather as a way of explaining that truth resides in the nature of being-in-the-world. Through our experience of being, we humans understand the world *as* something; this existential understanding is then objectified in language and other forms of expression. In contrast,

the traditional notion truth, which Heidegger (1936/1950, cited in Malpas, 2005) corresponds to *correctness,* which implies a one-to-one correspondence between a particular statement and the world – this way of thinking about truth that reflects the positivist concept of validity.

Although Heidegger did not refute the idea of truth as correctness, he maintained that it is subsumed by the more fundamental notion of truth as *unconcealment*. In the latter, truth is not inherent in the statements made about the world, but in the process by which phenomena in the world and what is said about them come to be one and the same. For Heidegger, the possibility of correctness resides in unconcealment (Malpas). As Parker Palmer (1998) frames it, "… truth [is] being involved in an eternal conversation about things that matter, conducted with passion and discipline … truth is not the conclusions so much as it is the process of conversation itself … if you want to be in truth you must be in conversation" (p. 104).

How should the knower acquire knowledge?

The answer to this question directs us to methodological considerations of the research process. Qualitative research is an umbrella term that arches over a number of separate and distinct inquiry traditions, each with their own philosophical underpinnings; theoretical, ontological, and epistemological orientations; methods; and purposes (Denizen & Lincoln, 2002; Rolfe, 2006). Broadly stated, qualitative research is

> … a situated activity that locates the [researcher] in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study the world in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people bring to them. (Denizen & Lincoln, 2000, p. 3).

Because a wide diversity that exists within the qualitative paradigm, it is possible to offer only the most general statements about 'qualitative methodologies' in a collective sense.

Qualitative methodologies are inductive in nature and tend to favour dialectical, recursive, and emergent designs. Not surprisingly then, qualitative 'data' are also extremely varied but are typically non-numerical. These may include texts (e.g., historical or literary texts, research reports); conversations or in-depth interviews with individuals; and direct observation (e.g., ethnography, participant observation, photography, and video recordings). In the course of a research project, a qualitative researcher engages with these various materials, describes, interprets, and/or analyzes their meaning(s), and then pieces these together into a unique understanding of the phenomenon or experience in question.

For Weinstein and Weinstein (1991), this summons up the image of the *bricoleur* first described in Claude Lévi-Strauss's *The Savage Mind.* Quoting Lévi-Strauss, Weinstein and Weinstein explain that in common French usage, a bricoleur "is someone who works with his hands and uses devious means compared to a craftsman" (p. 161), who presumably has no need to scrounge for materials. A bricoleur is a creative, resourceful, and practical person who uses whatever materials are at hand to create a unique product (*bricolage*). Even when given the very same materials, bricoleurs such as quilters and artists will each create something unique. Similarly, because qualitative researchers do not assume a single unitary reality, their unique and situated experience contributes something new and valuable to the collective understanding of a world that, because of the limits of being human, we cannot fully know.

Interpretive Inquiry

Schwandt (2000) describes interpretive inquiry as one "epistemological stance" (p. 189) within the qualitative paradigm. In physical terms, an individual's stance refers to the way that they stand. It reflects something about where they are located in time and space and conveys information about the ground they stand upon, what they can see and cannot see, as well as something about how they are engaged with the world. For example, the *two-point stance* of a defensive end in North American football is very different in nature, purpose, form, and location from a ballet dancer *en pointe*, a down hill skier schussing down a mountainside, and someone waiting in a long cue. In another sense though, the word stance also refers to an individual's attitude or worldview. Used this way, the term stance conveys something about an individual's ontology (way of

being) and epistemology (way of knowing), which in turn tells something about one's personal history, meaning systems, values, and motivations. It may also offer insight into one's position in relation to particular ideologies, situations, and events.

Interpretive epistemologies share the belief that human behaviour is meaningful, a commitment to interpreting and understanding human experience-as-it-is-lived, and an emphasis on intersubjective knowing (Schwandt, 2000). Guided by these tenets and employing various methods, interpretive researchers in the human and social sciences investigate the meanings of experiences of interest to their particular discipline. The resultant texts contribute both to disciplinary knowledge and to the larger collective understanding of lived human experience.

As I have framed it, my research question – *What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?* – seeks a greater understanding of the meaning and significance of pregnancy and birthing for women who have experienced childhood sexual abuse. My goal *is not* causal explanations, theories, or the identification of 'clinical symptoms'. Rather, my intent is to reveal their lived experiences of pregnancy and birthing. I want to know what it is like for these women to live in the world as women, as pregnant women, as birthing women, and as mothers. What impressions, feelings, sensations, stories, and anecdotes linger with them from these experiences? What meaning and significance do these things have in their lives? What can nurses learn about health and healthcare from a deeper understanding of these women's experience?

Methods

The methods used in this inquiry are guided by approaches to human science research articulated by Benner (1994), Kvale (1996), Morse (1991, 1994), Morse and Richards (2002), Munhall (2007), and van Manen (1997, 2002a, 2002b, 2002c) and are grounded in the philosophical and epistemological traditions of Continental philosophy, and human science research. More specifically, it involved my engagement in "the dynamic interplay among the following six research activities" (adapted from van Manen, p. 30): (1) turning to a phenomenon that holds personal meaning and to which I am committed; (2) investigating the phenomenon as it is lived, rather than as it is conceptualised; (3) reflecting on essential themes that characterise the phenomenon; (4)

describing the meaning and significance of those themes through writing and re-writing; (5) maintaining a strong nursing orientation to the phenomenon; and (6) balancing the research context by considering the parts in relation to the whole.

Sources of information

In the conduct of this inquiry, I spoke with women who have histories of sexual abuse about their experience of pregnancy and birthing and consulted a variety of texts. The texts included fictional and non-fictional works about girls' and women's experience of childhood sexual abuse, as well as women's experiences of pregnancy and birthing. I also consulted the research and clinical literatures in the human and social sciences.

Participant recruitment

Because my goal is the creation of a rich and detailed textual description of the experience of pregnancy and birthing of women with histories of childhood sexual abuse, I was less concerned with the number of women I spoke with (i.e., sample size) than I was about their reflexivity and their willingness to share specific details about their experience with me. The seven women who participated in this inquiry have been pregnant and birthed at least one baby. They range in age from 23 to 60 years, are fluent in written and spoken English, and gave their written consent to participate. They learned of the study through (1) advertisements in two local publications (*Birth Issues* and *Edmonton Women*) that have wide local distribution; (2) posters in various locales throughout Edmonton (including public health clinics); or (3) by word-of-mouth. I contacted two women via email and invited their participation. These women are both public figures in Canada and who have published and spoken openly about their experiences of childhood sexual abuse.

This method of selecting participants reflects what Glaser and Strauss (1967) term *purposive* or *theoretical sampling*. It rests on the premise that the researcher's knowledge of the topic area enables them to identify individuals who can contribute meaningfully to the aims of a study (Morse, 1991, 1994; Morse & Richards, 2002). This non-probability approach is commonly used in qualitative research and relies on the researcher's judgement in selecting information rich-sources for in-depth study of the question of interest. While it does not allow generalization of the findings to all women who have

histories of childhood sexual abuse, it does offer insights into possible human experiences.

The conversational interviews

As part of my exploration of the experience of pregnancy and birthing of women with histories of childhood sexual abuse, I engaged in conversational interviews with women who participated in this inquiry. These conversational interviews were either face-to-face or via telephone and lasted 1½– 2½ hours. The exchanges were audiotaped and later transcribed.

The word conversation derives from the Latin *convesari*, which literally translates as *turn about with*. According to the Oxford English Dictionary (Simpson, 2007) the earliest recorded use of the word conversation was in the 1340s, when it meant "living or having one's being in a place or among persons … living together, commerce, society, intimacy … sexual intercourse". All of these usages emphasize the personal, reciprocal, and engaged nature of conversation. It is in this sense, that the conversational interview reflects the epistemological foundations of human science research.

Teinar Kvale (1996) offers two metaphors to illustrate different approaches to the research interview in different knowledge paradigms. The first is the *interviewer-as-miner*, whose purpose is to extricate nuggets of knowledge from deep within a subject or participant's interior using a set of prescribed processes. Kvale's second metaphor characterizes the *interviewer-as-traveller* in new and unfamiliar territory. The interviewer-as-traveller explores the terrain and talking with inhabitants. He or she may also employ methods (from the Latin *methodus* meaning a 'way of teaching or going') such as maps or guidebooks to direct them to sites or individuals of particular interest to them. Throughout the journey, the interviewer-as-traveller endeavours to remain open to many sources and forms of information about cultural practices, language, important places, and significant events. When the researcher communicates with others about what they have seen and heard, the re-telling is from his or her own perspective. The original stories "are remoulded into new narratives, which are convincing in their aesthetic form and are validated through their impact on listeners" (p. 4).

The interviewer-as-traveller is transformed by the journey itself and by their interactions with others. According to Kvale (1996), this transformation is reflected in the

German word *bildungsreise*, which refers to "a scholarly, formative journey" (p. 4). Evidence of this change is manifest in the interviewer-as-traveller's participation in the co-creation of new knowledge (i.e., novel and rich insights) about a phenomenon. Furthermore, those who hear or read accounts of the traveller's stories may also be changed. The metaphor of interviewer-as-traveller resonates with post-modern notions of co-constructed knowledge, intersubjectivity, situated particularity, and a tolerance for ambiguity. It is this view that guided my encounters with the women who spoke with me about their experiences of pregnancy and birthing.

I did not prepare for the conversational interviews by composing a list of 'interview questions'. Rather, I approached each woman with a genuine curiosity about her experience and set of general questions that I might use to open the discussion, to bring the phenomenon of interest into focus, and to invite detail and specificity. Some of these included:

1. Tell me about your experience of pregnancy and birthing.
2. What was it like when you learned that you were pregnant?
3. What was the physical experience of pregnancy and birthing like for you?
4. Tell me about your labour and birthing.
5. What were the most difficult aspects of pregnancy and birthing?
6. What were the most surprising aspects of pregnancy and birthing?

During these conversations, I attended closely to the women and what they said. As they spoke, I repeatedly invited anecdotes, examples, and concrete and detailed descriptions of their experiences. I listened carefully, allowed space for silence, and frequently reflected back my understanding in order to clarify what they had said.

Ethical Considerations

The over-riding ethical consideration in all research involving human beings is that the welfare of those who participate supersedes the advancement of knowledge. To that end, I made every effort to safeguard the health and integrity of those who participated in this inquiry. Although I did not ask participants about their experiences of childhood sexual abuse directly, some of the women did speak of them. A few of the women cried or expressed other emotions as they spoke. When this happened, I validated their feelings and offered verbal support. By the time our conversations ended, all of the

women had regained emotional equanimity. They also identified self-care strategies they could employ and/or supportive individuals that they could contact if they became felt distressed in the days following our conversation. Although none of the women requested it, I had available a list of local support/treatment services.

The study was co-supervised my doctoral advisors (Dr. W. J. Austin and Dr. K. M. Hegadoren), under the auspices of the University of Alberta Health Research Board. In accordance with the latter, I provided each participant with a written synopsis of the study (Appendix I) and encouraged them to ask questions and express any concerns prior to signing a consent form (Appendix II) and throughout out encounters. In order to safeguard their identities, all but two participants choose pseudonyms that I used throughout our conversations and will continue to use in all subsequent reports of the findings.

All forms of information (i.e., audiotapes, digital recordings, transcripts, and field notes) collected during the course of the inquiry will be stored in a locked cabinet for five years after the completion of the project, at which time they will be destroyed.

Analysis

Analysis in interpretive inquiry is ongoing throughout the project and "requires that researchers dwell or become immersed in the data" (Streubert & Carpenter, 1999, p. 60) and to craft a text that captures the essential meaning of an experience. Because there are no strict rules or prescriptive protocols for interpretive analysis, it is by nature a creative process; one informed by the scholarly traditions of human and social science research (Benner, 1994; Kvale, 1996; van Manen, 1997).

During the conversational interviews with the participants I listened carefully to their descriptions of their experience of pregnancy and birthing, probed for specificity and detail, and repeatedly read the resulting transcriptions for recurring themes. Throughout the project, I was engaged in an ongoing dialectic between the transcripts as a whole and their constituent parts (i.e., the particulars of women's lives); between an individual woman's experience and the themes that are apparent across all of their experiences of pregnancy and birthing. This challenged me to "continually [shift my] attention from the foreground to the background, from the global to the individual, from the shared to the unique" (Godkin, 2002, p. 46).

As van Manen (1997) explains, the construct of 'theme' is widely used in the humanities and human sciences. "In literature, 'theme' refers to an element (motif, formula, or device) which occurs frequently in the text" (p. 78)"; a theme may be expressed as recurring words, phrases, sentences, or blocks of text that capture and express significant ideas, concepts, or feelings. Themes serve as ports of entry into the meaning of a text, as they provide insight and/or draw attention to essential elements. Unlike categories, which tend to be fixed and rigid in nature, themes are more fluid and subtle, yet they "somehow [seem] to touch the core of the notion we are trying to understand" (van Manen, p. 88). That being said, Bergum (1989) cautions against making too much of themes and reminds us that they reflect incomplete, oversimplified views of an experience. It is important to keep in mind that a theme is not something encountered in a text, but rather a way of illuminating meaning. With this in mind, thematic analysis is a useful heuristic device in the larger process of interpretation.

Writing, reflection, and re-writing are fundamental activities during the interpretive process (Benner, 1991; Bergum, 1989, 1994; van Manen, 1997) that is never fully complete, but ends when the researcher has "reached a *'good Gestalt'*" (Kvale, 1996, p. 48). This occurs when the researcher's understanding has inner unity, coherence, and consistency (Kvale). Asking others (e.g., participants, colleagues, supervisors) to read and reflect on the themes, and to offer feedback has been invaluable in helping me to refine the themes and to evaluate whether the text is grounded in lived experience, textured, and evocative (Benner, 1994; Bergum, 1989; Jardine, 1992; van Manen, 1997).

In the next chapter, I present excerpts of the women's responses to my invitation to tell me about their experience of pregnancy and birthing. Because these first-person narratives come directly from the transcripts of our conversations, they bring each woman's distinctive voice into the conversation that is this text. As Vangie Bergum (1989) says in her book, *Woman to Mother*,

> [e]ach story, with its own texture, its own feeling, its own image, arises from incidents in the everyday lives of these women. Each story reaches below the surface uncovering fragments of one person's experience which others can incorporate. Storytelling, as an interpersonal event, carries with

> it traces of the storyteller clinging to the text – like the hand prints of the potter on the clay vessel. (pp. 17-8)

Like all human experience childhood sexual abuse and pregnancy and birthing are complex, dynamic, and multidimensional, making it impossible to apprehend their full lived meanings. Every telling about an experience simultaneously reveals some things and conceals others. In her narrative, each of the seven women describes facets of her own particular and situated experience of pregnancy and birthing. Together the narratives offer new understandings that traverse the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse.

The three chapters that follow the women's narratives represent the interpretive work of this project. Their titles – *Living in the Wake of Childhood Sexual Abuse, Response-Ability to Motherhood,* and *Regeneration* – are the themes in the women's narratives that seem to me to address different aspects of the research question. While all of the women talked about all of these things to some extent, some of them spoke at length or were particularly enlightening with respect to a certain theme. Shirley and Kate's narratives highlight '*living in the wake of childhood sexual abuse*' and open up questions about the lived experience of sexual abuse. What is the nature of sexual abuse? How does it affect a girl's subjective sense of her body … of her self … of her relationships with others? How does it shape her beliefs and feelings about pregnancy and birthing?

Elly, Chloe, and Debbie's narratives show us women's different responses - their '*response-ability to pregnancy, birthing, and motherhood*'. This illuminates what it is like when a woman with a history of childhood sexual abuse learns that she is pregnant. Is she ready to assume the obligation of caring for a child? What things contribute to this sense of readiness? What happens if those things are absent? How does she experience her body as it changes to accommodate the child developing her womb? What is it like for her having to share her body? How does she relate to her unborn child … to that child in her arms?

The theme of *Regeneration* is most evident to me in Jane and Sharon's narratives. Their descriptions open the possibility of pregnancy, birthing, and motherhood as life altering experiences. Bergum (1989) writes that although we tend to speak of the

transformation from woman to mother in linear terms, the change that occurs is "deep, complex, and dramatic" (p. 36). According to Robin Morgan (1984), "[h]aving a child drastically changes the lives of most women, opening up previously unimagined new selves, new areas of responsibility, delight, exhaustion, anxiety, ambivalence, and physiological change" (p. 223). Does pregnancy and birthing change women with histories of sexual abuse? If so, in what ways?

As I reflect on this process of interpretive analysis – of reading, questioning, listening, discerning, writing, and rewriting – I am aware of a constant tension that arises out of my own being-in-the-world as both a nurse and nascent interpretive researcher. As a nurse, much of my attention and energies are focused on the related topics of women's health, psychological trauma, stress, and childhood sexual abuse. I read the professional literatures, attend conferences and workshops, and work intimately with women whose lives are touched by violence. All of this influences my 'horizon' of understanding (Gadamer, 1975) about childhood sexual abuse, pregnancy and birthing, motherhood, and about research traditions and practices. While these things are the "forestructure[s]" (Thompson, 1990, p. 241) that enable me to understand human experience, they also bias me.

These prior understandings are like deep ruts in a winding dirt road; when I slip into them, I am a clinician. I adopt a "clinical gaze" (Foucault, 2003, p. 132) and use language that frames individuals as patients or clients and frames lived experience in terms of health or pathology. Although this way of seeing the world may be appropriate and even useful in some settings, it also impedes my efforts as an interpretive researcher to keep the question before me open and to remain sensitive to the limitless possibilities for understanding. More than once during this project I needed coaching to shed my clinical lens and to readopt an inquiring attitude that asks *'Is that what this experience is really like?'*

Van Manen (2002d, 2002e) offers the notion of *tact* as a way to bridge the apparent dichotomies that exist between intellectualized theory and interpretive inquiry, between human 'being' and professional practice. Simpson (2007) defines *tact* as an "intuitive perception of what is fitting esp. of the right thing to do or say…" van Manen further explains that it

> …can neither be reduced to some kind of intellectual knowledge base nor to some set of skills that mediates between theory and practice. Rather, tact possesses its own epistemological structure that manifests first of all as a certain kind of acting: an active intentional consciousness of thoughtful interaction. (van Manen, 2002d)

Because a central aspect of my own being-in-the-world is as a nurse, I perceive, think, and act intentionally in the world as a nurse. I cannot separate my self as a nurse from the many other parts of my self (i.e., woman, daughter, sister, wife, mother, academic researcher, etc.), nor do I even want to try. All of these things interact to create my own particular and situated consciousness, which in turn enables me to offer a unique perspective on the question of interest in this inquiry. Just as each of the sources of information that I consulted in the conduct of this research contributes something valid to the understanding of pregnancy and birthing of women with histories of sexual abuse, so does this text. My ongoing challenge in this work and in life is not to privilege one way of knowing over another, but to keep myself open and attuned with different ways of knowing and to act tactfully and with ethical intention in all things.

In the following sections, as I move back and forth between the language of interpretive inquiry and clinical nursing practice, my intent is to simulate an ongoing 'conversation' between the women's lived experience and interpretations from various literatures. During this 'conversation', I will use language that reflects both ways of knowing, but always with goal of deepening my understandings of the lived experience.

Appraising an Interpretive Inquiry

The question of how best to judge the authenticity and credibility of an interpretive inquiry has been contested for several decades. As Sandelowski and Barroso (2002) observe,

> [s]cholars across the practice and social science disciplines have sought to define what a good, valid, and/or trustworthy qualitative study is, to chart the history of and to categorize efforts to accomplish such a definition, and to describe and codify techniques for both ensuring and recognizing good studies. (p. 2)

Despite these efforts however, it seems that we have made little progress in "establishing a consensus on quality criteria, or even on whether it is appropriate to try to establish such a consensus" (p. 2). Some factions in this debate contend that qualitative research should be judged by the same criteria as quantitative research (e.g., Morse, Barrett, Mayan, Olson, & Spiers, 2002), while others advocate for the use of unique evaluative criteria specific to qualitative research (e.g., Guba & Lincoln, 1989). A third group (e.g., Koch, 1996; Koch & Harrington, 1998; Rolfe, 2006; Sandelowski and Barroso, 2002) argues that any attempt to establish a single set of 'epistemic criteria' for judging the value of qualitative research (as if it were a unitary entity) is futile, given the epistemological scope of qualitative methodologies. I agree with this last group and propose that evaluating an interpretive inquiry involves the consideration of both proximal and distal factors. That is, evaluation of the research report itself and its potential impact within the community for which it is intended.

Sandelowski and Barroso (2002) write that in practice, research is judged on aesthetic and rhetorical considerations because "the only site for evaluating research studies – whether they are qualitative or quantitative – is the report itself" (p. 8). On this view, the written research report serves as "a dynamic vehicle that mediates between researcher/writer and reviewer/ reader, rather than a factual account of events after the fact" (p. 3). This shifts the focus of evaluation away from determinations of objective truth (validity) and places it closer to the realm of literary criticism, with particular emphasis on reader-response criticism. With this change in focus, Sandelowski and Barroso also propose a change in language from *evaluation* to *appraisal*, which involves "the exercise of wise judgement and keen insight in recognizing the nature and merits of a work" (p. 10). What I am calling *proximal appraisal* of a research report rests on a judgement that is a function of the reader's insight and experience rather than on explicit predetermined criteria.

Angen (2000) reminds us that because interpretive understandings of truth differ from the correspondence theory of truth (validity), the importance of methodology and specific criteria for evaluating research fade into the background. Based on this, she proposes a "radical reformulation" (p. 387) of the concept of validity as truth, that realigns it with its etymological roots. The word *validity*, from the Latin word *validus*,

means *well, strong, powerful, or effective*, and *to have worth or value* (Simpson, 2007). This introduces the notion of 'goodness', which highlights moral and pragmatic concerns as a basis for appraising all scientific endeavours. Validity, Angen asserts, "... must be located within the discourse of the research community, and judgements must rely more on the moral and practical underpinnings of the inquiry than on methodological criteria" (p. 387).

Recently, scholars and researchers working within the interpretive tradition have attempted to develop new understandings of validity that reflect their ontological and epistemological assumptions. Unfortunately, because most of them use different terminology for related concepts it has been more confusing than not. In an effort to introduce some clarity, Angen (2000) has summarized these efforts under two broad headings – *ethical validation* and *substantive validation*. These, I propose, offer an approach to the *distal appraisal* of an interpretive inquiry.

Ethical validation

Smith (1990, 1992) believes that interpretive inquiry is as much an ethical endeavour as it is an epistemological one. The widespread recognition of the impossibility of value-free science, similarly leads Fiumara (1990) to conclude that the moral assumptions underlying all research agendas must be closely scrutinized. Moving this a step further, Kvale (1996) states that *beneficence* (to do good) should be the fundamental guideline for all research and practice, while Flax (1990) and Lather (1986) maintain that ethical research – research that promotes the greatest good – is that in which all voices are heard and diversity and ambiguity are not ignored. Appraising the ethical validity of an inquiry asks: Does the choice of a research topic and method(s) promote the greater good, acknowledge diversity and vulnerability, and enable us to "remain connected to our shared humanity" (Angen, 2000, p. 388)?

A second aspect of ethical validation is *usefulness*, which is evident in the answer to the question 'so-what?' (Angen, 2000). Does the inquiry expand horizons of meaning and understanding? (Gadamer, 1975) Is it generative in nature? That is, does it offer the possibility of new questions for exploration; does the work stimulate thinking and dialogue? In a practice discipline like nursing, the ultimate usefulness of any inquiry resides in its potential to influence nursing practice. In large part, this is a function of

dissemination, but once in the practice environment does this work hold the promise of improving women's health and healthcare?

Substantive Validation

"Having ruled out methodology as the basis for validity, the substance of the inquiry becomes an important focus for evaluating an interpretive piece of research" (Angen, 2000, p. 389). How well does the researcher demonstrate the complexity of the topic? How well do they honour and give voice to both current and historical, intersubjective understandings of their topic (van Manen, 1997)? Do they offer their own evolving understandings as well as those from other sources? Is there evidence that the author's interpretations converge with those of the participants and other sources of information (Draucker, 1999)?

In actuality, an interpretive inquiry involves a series of interpretations and these must be evident in the written report so that readers may appraise their trustworthiness (Nielsen, 1995). To that end, is the written account thorough and comprehensive? Does the conceptual development follow a clear and logical path (Morse, 1994)? Does the writing resonate with its intended audience? Are the arguments compelling, powerful, and convincing? (van Manen, 1997)? Do they expand the reader's horizon of understanding and evoke a feeling of authenticity? Is the reader moved by the work?

What follows next in Chapter 6, women with histories of childhood sexual abuse describe their experiences of pregnancy and birthing.

CHAPTER 6

PREGNANCY AND BIRTHING: WOMEN WITH HISTORIES OF CHILDHOOD SEXUAL ABUSE DESCRIBE THEIR EXPERIENCES

> Stories are habitations. We live in and through stories. They conjure worlds. We do not know the world other than as story world (Mair, p. 127)

Exploring the meaning of lived experience is at the heart of interpretive inquiry. For Gadamer (1975), this goes far beyond the simple description of an experience and tries to get at the enduring content of that experience; "its discovered yield, its lasting residue" (p. 56). Through the act of 'storying' our lives, we weave the diverse elements of an experience into a *Gestalt* – "a perceived organized whole, that is more than the sum of its parts" (Simpson, 2007). These personal narratives or stories contextualize an event or an experience by incorporating them into the continuous fabric of our past, present, and future. In this way then, they are not merely a descriptive account of a period in our life, they are a means by which we impose order and make sense of a world that is at times, chaotic and incomprehensible (Clandenin & Connelly, 2000; Draucker, 2003; Polkinghorne, 1995).

All personal stories or narratives are presentational in nature, that is, they are not fixed, verbatim accounts of the experience being described (Sandelowski, 1991); instead, they are evolutionary and subject to change. A changing description not imply that some versions are less 'accurate' or 'true' than others; the elements we choose to include, emphasize, or exclude from a particular telling about an experience reflects something about our purpose in telling it, our audience, our current situation, and our cumulative understanding of our self-in-the-world. "Rather than being seen as the equivalent of videotapes of a life experience, [stories or narratives] are more like a continually evolving sketchbook of memories and life experiences" (Gilbert, 2002, p. 225).

This chapter presents the first person narratives of the seven women who participated in this inquiry. My intent in doing this is to enable readers to hear each woman's distinctive voice. Like the women themselves, the experiences they describe are unique and reflect their diversity of experience. Individually and collectively, the stories

contribute something to an understanding of the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse.

One of the women had her sixtieth birthday this year, another is in her fifties, one is in her thirties, and two are in their twenties. Their children now range in age from forty years to one year old. One woman, Kate, was pregnant with her third child when I spoke with her. Since we last spoke, Jane has become pregnant with her second child. Three of the women are of Aboriginal heritage. The women's incomes range from below the poverty line to 'comfortably middle-class'; their formal education includes grade ten equivalent to university degrees. Five of the women live in Alberta, one lives in B. C., and the other one lives in Nova Scotia.

Because I was interested in hearing what aspects of pregnancy and birthing were the most salient for each of them and did not want to lead them in a particular direction, I began each conversation with the invitation: 'Tell me about your experience of pregnancy and birthing'. Once they began describing their experience, I asked questions to clarify my understanding and to invite more detail. Some of the women talked about the sexual abuse itself and how it has affected them self and their lives apart from pregnancy and birthing, others mentioned the abuse only in passing or not at all. Our conversations lasted 1½ to 2½ to two hours. Afterwards, the women read the transcripts of our conversations and were asked her to reflect and comment on the themes that I identified.

The women's narratives appear below under the themes of *living in the wake of childhood sexual abuse*, *response-ability to pregnancy, birthing, and motherhood*, and *regeneration.*

Living in the Wake of Childhood Sexual Abuse

Shirley[11]: Girl Interrupted

I always felt like I was a mother to my brothers and to my sister

I was heavily into my career because I had been told, around age fourteen, that there had been a lot of damage from my father - a lot of physical damage – and that it was quite unlikely I could ever get pregnant. So I'd never taken precautions not to get

[11] Shirley Turcotte consented to be known by her full name. Her National Film Board film *To a Safer Place* (1988) was one of the first to address the problem of childhood abuse in Canada. In her film, she revisits her home community and talks a bout her own process of healing. Shirley now works as a psychotherapist in Vancouver, BC.

pregnant as an adult woman. I just assumed it would never happen to me, so I was pretty much in a state of shock at the beginning.

I never wondered much about what it would be like to be a mother because I felt like I already had done that - I still feel this way - that I had done a lot of parenting. I felt like I had raised my siblings and I don't know a time when I didn't feel like a mother, you know? Like a many children who live in dysfunctional homes, I was the child who took the role of being mom; I always felt like I was a mother to my brothers and to my sister. I felt old and like a parent before I ever became a parent. So, um, and I had no desire, of children, because I felt pretty exhausted and worn out by parenting already as a child. I knew that is an awfully huge responsibility. When I left home, I felt free for the first time in my life. I have always resonated with Shania Twain who raised her siblings, because they were little kids when their parents died. I just felt her story was really like my story and like that of a lot of Aboriginal people - my father is Aboriginal, I don't know if you know that.

I had no idea what a joy it would be

I had no illusions about what it would be like to have a child and how much work that would be. What I didn't know though, what I had no idea about, was what a joy it would be. I think that during all those trauma years – being a child trying to raise kids was so stressful and so terrifying, because you're trying to protect them all the time from, you know, rape and from, physical abuse and starvation ... things like that. It was so, so much work and so horribly scary. I was afraid for them all the time... I had no idea what a joy it would be to parent when you didn't have to protect a child from everyone... like parents who were just ... you know, so dysfunctional.

It was interesting, I felt like I was pregnant but I thought that was ridiculous ... it wasn't possible! My breasts were sore ... and I don't remember if I had missed a period, but ... I just knew I was pregnant. I was quite connected to my body I and I could feel this ... this difference, so I went to the drugstore and got a test kit. There's no way I wanted to, look at it or to know the result, so I peed and left the specimen with my husband. At that time, I was in Engineering and he phoned – I asked him to call me when he got my test results – and said, 'You're pregnant. We're going to have a baby'.

I totally felt that there was something foreign, a foreign person, inside me

I felt kind of stunned. I don't think I started to really get post-traumatic at that point, but that would come. When I first found out I was pregnant I was shocked and then I developed this hallucination or something – they were always really good for me - to help me through trauma. I invented this 'knowing' that the baby was a little girl and that just made everything safe. So for the entire nine months, I was attaching and connecting to this beautiful little girl ... I was really clear in my mind that this was a little girl. So I did okay through my pregnancy, although because of damage by my father, it was a very disruptive pregnancy, but I had a lot of problems in the pregnancy.

I didn't feel like the baby was taking control of my body. I totally felt that there was something foreign, a foreign person, inside me and I did not feel a big sense of attachment at all. It was like that Sigourney Weaver film where she had that alien inside of her. It didn't feel like it was part of me. I wouldn't help it or hurt it, but I would do the best I could for it to make it through ... and I would certainly never destroy it.

In my fifth month, I was losing amniotic fluid and was on bed rest for an entire four months, which was really hard for me. Because the baby's life was at risk, they wanted me to do this procedure where they stitch your cervix, but I refused. I had a feeling that this baby was going to come and nobody must touch this baby. I can see now that that was a traumatic response. It affects me even now, as I talk about it - I was afraid for anybody to touch the baby or for anybody to have any contact with the baby. Whether that was a medical person or anyone else ... I knew if they did a procedure on me ... I would lose the baby.

We were at complete odds with each other, the doctors, and me

I became very protective of this little baby girl and I must not have any medical procedures. Of course, that was a real problem for the medical people and they tried everything to get me to do the procedure. It was pretty awful because there was an insinuation that I was, um, already a bad mother so-to-speak because I was putting this baby's life at risk by not doing these medical procedures. What I did agree to do was the bed rest. I stayed horizontal for a number of months.

I had a very bad, had a very bad relationship with the medical people..., which is too bad, right? We were at complete odds with each other, the doctors, and me... I was quite determined that this, baby not be touched. The baby was premature, not a lot

premature but the birthing was absolutely horrendous. It was a horrible, horrible situation. I kind of knew it was going to be complicated so I didn't think about having a midwife ... I don't know, I just knew it was gonna be a mess, and it was a mess. The baby - James[12] *- was face-up and he just wouldn't be born. He just wouldn't come out.*

After many, many hours of labour, they had to do an extended episiotomy and you know... a spinal or whatever they do ... an epidural ... and it was really very messy... They had to use forceps and I was extremely frantic. I think that I must have been in an acute posttraumatic stress state; I was frantic that these people were going to take this baby. I was yelling at my husband to get the baby away from these people. I had complete distrust for everyone in that room ... it was really quite traumatic. So my husband did take the baby eventually... and then there was a problem because he was a boy and not this girl that I had imagined.

My God, he could be ... he could be my father

I was really frightened for him. I was just really frightened for him and wanted him not to have anything to do with me. I wanted my husband to have the baby and nobody else ... nobody that was associated with me should have the baby ... this would be my husband's baby.

I was having all kinds of flashbacks and at the bottom of it all ... I had this horrible fear that my son would have, you know, the genes of my father. That he would somehow ... the sexual abuse, the physical abuse done to me or my body ... I could probably get through that. What I couldn't get through and what never does sit right for me was the thought of other people being hurt. That a member of my family - that my father - could hurt people like that ... that to me was the unbearable... despairing ... unacceptable part for me in all the trauma. The idea that my son, because he's a male, could have anything in him that might make him do something like that to another person was really frightening. I had the sense that maybe it was something genetic ... that I passed on the genes of my father and all the things that he could do ... that was the most horrifying bit. My perception of women was a little bit different. The worst thing that could happen if you were a girl is that you could be like my mother who was docile and not able to hurt a flea.

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[12] Pseudonym

There is no aggression in my mother whatsoever, just plain negligent beyond anything that anyone could imagine. So negligent that she could know that her children were being tortured and abused and she would, still pass the child back to their father, right? So here, you have these two extremes, this extremely passive mother who is like an eight-year-old child ... not able to do anything, not even banking. She is developmentally arrested. It makes sense that my father would marry a child because he's – my father was not an alcoholic – he's not your typical Aboriginal man. He was - and must be still - intensely pedophiliac. So I'm not surprised that he would be with a childlike woman. To this day there is nothing adult about her; she's eighty-seven pounds... she doesn't have breasts, she doesn't have hips... she never has had anything about her body that was womanly... or in her mind. She's doesn't have a womanly mind either. And that's non-threatening... for me that's non-threatening.

The threatening piece for me is not only that my father could do those things, but that I am responsible for him on some kind of cellular level. I have to undo or repair the damage that he's done ... to balance the sheet. My life has been completely dedicated to work in this field, right? Trying to make it all better, which of course is a completely impossible task. [Laughs] It's been fun all the same; it's a good way to spend your life. The motivation under it all really comes from a very deep core inability to handle my father's behaviours. So what if my son...? If it's a girl that's not an issue, but if it's a boy "Oh my God!" right?

I didn't understand what my anxiety was all about after his birth.... I didn't know why I was freaking out. James was born 25 years ago when there were very few trauma experts. People had no idea how to work with trauma in those days. They really didn't know what a flashback was or anything really. It was really difficult to get good help and so mostly I would be figuring out that stuff out myself. I had a really good, ability to do that, to sit, and self-reflect and to be able to notice when something was a flashback. I have good ways of attending to myself because I was working with trauma survivors in therapy groups. I was quite self- reflective and knew when something was over-the-top there for me. I just asked myself, deeply, "Why? What're you so afraid of?" and there was this horrible answer that came deep, from deep within me – "My God, he could be ... he could be my father". It was very frightening.

After the birth, I felt "Get the baby over to Peter"[13]*. I guess I felt like a desperate eleven-year-old trying to save this baby's life... In retrospect, I didn't want the baby with the, you know, the professionals or the authoritarian people who were like my father to me in that moment. I didn't identify my husband with my father – some survivors do that - they identify their partners as their fathers. I never identified my husband like my father. I identified my husband like with brother. My husband was my brother. He was safe and everybody else was unsafe ... My husband was also a survivor. He survived the Second World War. He was abandoned as a little boy in his village when his parents died. I identified with him as if he were my brother ... another person who'd been through so much, right? I was trying to get the baby away from authority figures. Anybody older, anybody adult ... no-one adult was safe, only children were safe.*

Through him, I had another childhood

At first, he would not attach to my breast, so there were huge feeding issues ... Trying to get nutrients in him was a real struggle. In fact, we went through three nannies in three months ... finally we found someone who stayed with us for years. She really helped me in that, first year the impossible year when the neighbours were reporting her for child abuse. Of course, there was no child abuse; he just screamed and screamed and screamed. He could not stand to be held... he was about to get tested for autism or something. And again, I just really had this thing about not wanting anybody to interfere and I had this breakthrough with him.

I closed the door of his bedroom - he was about eleven, twelve months old – and spent a couple of hours just, you know, trying to connect with him ... to see if I could see what was wrong. I don't know how to explain ... it was almost like, "Ok we are not, we're not leaving this room till we've figured this out" ... and what I came up with was that he needed to be off all soy products and all milk products. Again, the medical people were saying, "No, you can't do that". But that's what I did. I took him off all milk and put him on meat and potatoes and [laughs] juice and he just completely turned around. Something shifted and he settled right down. I didn't keep the appointment at UBC because I knew he wasn't autistic... he just had a very unusual system.

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[13] Pseudonym

James was a very unusual child. He could read books in a mirror but he couldn't see them forward, so he had like a form of dyslexia. He was very smart, very talented, but everything was backwards for him. I don't know what that was all about. Uh, anyway, he's twenty-five now and applying for a PhD program in ecological anthropology.

Everything got just got better and better every year. We had a great relationship, a lot of fun. I had no parenting problems until he was about fourteen ... the teens were a bit complicated but not impossible. I felt that what he brought into my life was the ability to play. It was through him having his childhood and me witnessing a healthy childhood - how much he laughed - it was really wonderful. I think we had the best time of it because I had quite a bit of money. I was pretty lucky. I always had really good jobs and I always made lots of money, so I put all my money into hiring people to do all the work. You know... the housework and [laughing] stuff like that... so I had all of my free time just to play.

When I'd come home from work it would be to play with James not to run around cleaning and looking after things... I just spend all my time, you know, getting out the pots and pans and the music going and we played. We played a lot ... all of his life actually ... and we traveled a lot together. I think it's through him that I had another childhood. I mean I always was the adult but I learned how to laugh and how to scream when you're driving your cars through a tunnel. [Laughs] We used to see who could scream the loudest and the longest and you know. I learned how to make noise with my own voice and how to sing and dance.

He had a lot of problems with coordination so I put him in ballet and that was fun. If I would have put him in anything that was male-oriented, he would've been at the bottom of the barrel because he had no physical ability. Ballet taught him quite a bit of coordination and he loved it because he got to be the star. There were only two boys [laughing] so he always got the boy roles. Has a good life and he certainly helped me to have a really good life.

I felt very interrupted when I was eleven

I have a very different experience than a lot of abuse survivors who feel that they are incompetent, full of shame, and fear and all those sorts of things. I never had that. It didn't really matter to me what people thought and I always felt very capable... I think

that had to do with being, you know, always having to do everything. There was no mom there, and whether I had to kill a chicken to get food because we were always starving ... whatever, it didn't matter to me. I always thought there wasn't anything I couldn't do ... it didn't matter whether it was a male job or a female job. In a way, when I look back at all the things I've done, I'm kind of shocked that I could be an engineering manager, or ... that I could write a book and it would get published ... that I could make a film and somebody would pick it up, you know. That I could become a psychotherapist and lecture across the country ...

Another piece about birthing James that was also frightening - I don't know if I have talked much about this in public - but, when I was about ten or eleven, I got pregnant and my father did a procedure in the bathtub with a coat hanger and very hot water ... how crazy that time was... I bled for a long time, many, many days. I'm sure that was part of the damage ... why they thought I could never get pregnant. But there was this feeling ... I mourned the loss of that child even though it was an incestuous child. I can't tell for sure if I had been pregnant or what my father was doing with that coat hanger. I can't be absolutely clear because I never was seen by a doctor and it was never really confirmed, but I believed that there was a baby and I grieved the loss of that child. For a long time, I felt like the child had been, removed from me and that was very troubling to me.

Even now as a clinician, having to help people have abortions is always a really difficult task for me because I don't believe in abortion, but I of course believe it is a woman's right... but on a very deep level, a core level inside my own body, I don't believe in abortion. If there is a child in me, it needs to come forward. It supposed to ... to come through... so there was this other aspect to having James ... that he was this child who has come again. On a spiritual level then, I felt that I knew him and that he'd been around for a long time and that probably is also part of what that sense of being, "Oh my God, he's my dad's child", right? It was a very complicated, a very loaded thing... but once I was aware of the terror that I was holding about James and I knew enough about his spirit, I could let the fear go. His personality and his spirit were so different from my father's and my mother's and even my own.

In a way, I was kind of reliving my life as an eleven-year-old time again. I didn't want to not have the baby and I didn't want to have the baby. I just wasn't going to interfere. I was sort of like in a state of paralysis. I was in a trauma state and the decision was going to be left to the baby. Which is, again, not at all clear thinking ... doesn't make any rational sense, you know, a baby can't decide [laughs]. But that's just the state I was in; I think labour took me back to being that eleven-year-old girl pregnant girl.

The thing that I felt the most inhibited about was the terror of [stammers], of pregnancy ... that kind of stops me in my tracks ... and I never did have another child, right? I felt very interrupted when I was eleven and that felt like an enormous failure. I would never have had another child. In fact, I had my tubes tied shortly after Steven was born, just to be sure.

It was a bloodbath

I think that decision had a lot to do with two things ... one is that incident in the bathtub with the coat hanger - the interrupted pregnancy – and the other is James' birth. It was a bloodbath as well. They had to ... his heart rate dropped and they had to cut me extensively ... and they had to do it fast. It seemed like there was blood everywhere. It was a bloodbath... a horrible bloody scene. A horrible, bloody scene that went back to the horrible bloody scene when I was eleven.

I don't think I've ever quite ... I can never get over the death of children. That's something, you know, that's a very hard thing for me. My body doesn't make birthing an easy task because of the damage that was there to start with. It is an awful thing to consider the life and death of this child growing in your body. "Are you gonna be able to make this happen? Is this baby going to make it? Are you gonna be able to perform the most important performance of your life to keep this child alive?" That's ... that's pretty formidable, for me personally. I didn't think my body could do that again. It was a miracle that, that James survived. I'm an excellent mother, but I am useless at carrying babies.

I can hear it in my own voice even now... I hold my breath around pregnancy. Lots of survivors don't have babies and others just keep having one after the other – one end of the spectrum to the other. Some survivors keep themselves very pregnant and have lots of children so they can avoid themselves. It can be a way to put their own lives on

hold; others will not have any children. I'm that kind of person. Survivors can be pretty fucked up around having children, before they've done their healing.

When my son was born I was not able to bond ... I just pushed him over to his father. I didn't want anything to do him, but I wanted to be sure that he was safe and protected, in good hands ... but it needed not to be somebody else ... not me. Because if it was me, then he ... he could possibly be a pedophile, he could be like my father. That is why I told myself through my pregnancy that I was carrying a girl. There was no room in my mind for the baby to be a boy, and so when James came out, he had no name... My husband had to name him because I ... I couldn't even go there.

I danced with depression off and on for my entire life

I definitely had post-partum depression after he was born. I don't know very many survivors who don't have dysthymia[14] for a good part of their lives... I think I danced with depression off and on for my entire life until finally my bleeding stopped. That is the best time in any survivor's life because finally all that hormonal stuff is over. Trauma is stored in the reptilian brain and that's where all that hormone stuff happens ... I am not saying this is true for all trauma survivors, but certainly after long-term trauma, depression is definitely part of the dance involving our hormones, periods, and pregnancies... Then finally in your fifties when your periods stop you finally see what life is like.

I think that menopause and post-pregnancy were very similar for me in that I had wide hormonal fluctuations and it does feel as if you have no control over your body and that your body's controlling you.

I don't like my body, but I don't think very many women like their bodies

I don't know very many women in our culture who actually - whether they have a history of sexual abuse or not - would say they have a really good relationship with their body... I don't think I like my body, but I don't think very many women like their bodies. Maybe it's harder for survivors, but I think it's hard for all women to like their bodies. I would say not liking my body is more a function of being a woman than it is of being a survivor. I don't know if that makes sense – but its how I personally feel. Even after you've done all of your trauma healing ... you're still gonna have a whole bunch of

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[14] Chronic, low-grade depression

friggin' body issues because of our culture... I mean I feel comfortable in my body now and I like myself... I wouldn't go do plastic surgery or anything... I'm getting older, my breasts are hanging ... but mostly what I'm concerned about in terms of my body is, "Do I feel healthy? Can I swim fifty lengths a day? Can my body give me the energy I need to do the things I want to do?" That's more what I think about in terms of my body in my fifties.

I had children to raise

When I was a child, there weren't any adults who were there for me. There really were no other adults who were safe. I mean none... Safety lay with my siblings and with nature. I was really connected with nature. I'm very lucky to have lived on a farm because it allowed me to be connected with the earth. In a way, there was a lot of freedom in not having any adults around ... there was nobody telling me what to do, so you did it all yourself... there was a freedom to that and an incredible beauty in the sense that I never really felt incompetent... I felt we could do anything and we did do anything. We did do everything that we needed to do. We raised ourselves.

The fact that I had children to raise ... I mean I think that's the best thing that ever happened to me. Not only did I have to do it all myself, but I had other people depending on me... That was amazing because when you have people depending on you there's nothing you can't do. You have to do it and that's what gave me the gumption. I mean I look at my other siblings who didn't have to raise other children, they did not... they weren't able to ... they didn't succeed. They didn't have to keep a piece of themselves out of the drama and trauma to go forward, to create a life for others. So they were one hundred percent buried in it. I see that now with other survivors. Those who had to look after others ... there is a part of their self that just didn't have time to get sick... I had to perform. I had to be able to make a lot of money to bring home food to put my brothers through school ... to get the winter clothing for my little sister ... to get her teeth fixed... Yeah. I was a great compartmentalizer because I had to be.

Kate: I have been Off Balance For a Long Time

I have been off balance for a long time

I kind of thought I might be pregnant so I went to a clinic in Calgary and the pregnancy test was positive. I didn't have my kids with me and I was on the street, so I

got off the street and, you know, started leading a normal life again. I'm doing better now and I'm excited to have a baby because I kind of missed out on my other sons' lives. I'm scared though, of labour and stuff, but I'm happy that I going to have another baby. I was in a treatment centre twice and I just completed one about a month and a half ago, two months ago. I'm looking forward to being clean and sober. It kind of affects me ... my health ... like my emotional health and my mental health and spiritual health and my physical.

In our culture, we believe in the four aspects of life- physical, the mental and the emotional and spiritual. They all have to be in balance in order for a person to be healthy; if you are off balance in one, you are off balance in all four aspects. I think that I have been off balance for a long time because I was probably about three or four when I started being abused by my uncle.

My grandma and grandpa lived just down the road and I would go over to visit. That's where my uncle abused me. When it started, I didn't know what to do. I was scared and I didn't know who to turn to; I didn't know who to talk to. I tried going to my great grandma's, but then another uncle moved in there and he started abusing me too - like in the house, with my other family around. That really scared me because I thought, "Somebody is supposed to be there to protect me". I wasn't feeling safe and I didn't know what to say. When I got older, I wasn't abused as much, because I started trying to tell people.

I told my mom and my dad about that abuse but they didn't acknowledge it. It's kind of like they put it on a backburner or something. That really hurt because I thought parents were supposed to protect kids. I think it happened to my mom. She hasn't like, said anything to me but other family members have told me that it's happened to them. I don't know ... we are a closed family – 'Don't feel. Don't talk', you know? We have a lot of family secrets and that's not really healthy because you can't really talk to anybody. It seems like the only feelings that I've ever felt are anger and regret ... I have been happy once in awhile, but mostly I am angry.

I was big when I was young – I had a lot of baby fat because I overate. On almost every holiday, I had to go to the hospital because I stuffed myself and got sick. I think that

I was addicted to food because I thought that if I made myself unattractive I wouldn't be abused. It didn't work though. The abuse still went on - I guess I was convenient.

I didn't really have like a kid's life

I didn't like myself, because I was, you know, big. I was fat and I was always looking after my brothers and sisters. I didn't really have a life - I didn't really have like a kid's life because I was raising everybody else's kids. I didn't get to enjoy being a child. I felt like that was robbed of me, you know? I've never played with Barbies or wanted to play 'house' because it was too much like my regular life. I was like this grown-up in a little person's body.

That's why I want to talk about the things that I've been through ... because I think it helps me. I want my kids to grow up and be healthy. I don't want them not to being able to express how they are feeling. If they are hurt, I want my boys to tell me and I won't turn them away or make them feel ashamed. I am glad that I don't have girls. I wouldn't want them to go through any of the things that I've been through. I try to protect my nieces and I ask them to tell me if anybody ever touches them or stuff like that. I don't want them to be exposed to that because it messes with you ... it messes with you in every way. It had a lot to do with why I turned to drugs.

When I started getting into my teens – I was back on the reserve then – that's when I started becoming promiscuous, drinking a lot, and smoking pot. Just getting into normal stuff - well nowadays it's kind of normal. Doing drugs and drinking on the weekends and stuff like that. I've always excelled at school, but I started hanging out and not going home.

I got pregnant at fifteen and I didn't know what to do. I was kind of ashamed and I didn't know what to tell my mom. I felt alone because my baby's dad wasn't there, he was in jail. I couldn't really see myself being with him for the rest of my life ... he was just there for the moment. I was scared and alone even though I was living with my mom and her boyfriend. They had been together for a long time but then, she was always going out. She had developed a gambling problem and she was hardly home.

I was allowed to smoke when I was 12 and I started smoking joints at thirteen. When we moved to the city, I started experimenting with hard drugs but didn't really get into them until I was 18 or 19. By then, I was by myself and homeless, living here and

there, smoking a lot of drugs, and having numerous partners. I have never really had a boyfriend until I got pregnant... but it never lasted. I have some contact with my first son's father but he's an addict ... he's into sniffing exhaust and lot of other crap – yuck! I don't know ... I picked unhealthy people to be my children's fathers and I feel bad about it because my kids don't really have fathers. My other son's dad is a crackhead in Calgary. Last time I was there, he threatened my life because I left my son with my mother.

My physical health has been in danger a lot of times and I could have lost my life a couple times. I've been beaten up. I've been ditched on the side of the road, you know, a country road. I put myself in a lot of danger just too ... just to have the numbness of not feeling those feelings of my childhood abuse. That's probably one reason I moved away from my family ... they were just a constant reminder.

I have never asked my sisters if they have been abused and I feel bad about that because if they have, then I could have helped them or talked to them, you know. I was kind of like their second mom, so they had to listen to me. I didn't really have a sister-sister role; it was like a mother-daughter role. I kind of regret being mean to them, you know, and my brother too. He's sixteen years old, seventeen soon. I feel bad because I put my anger and my family shame onto them.

I felt that somebody loved me and that I had somebody to love, like healthy love

When I was in the treatment centre, they said that some people who were abused sometimes turn into abusers and that scared me. When I had my first son, I was afraid to clean him ... like clean his like genital area... I didn't know what to do so I would, kind of leave it. I felt like, you know, "What if I get those kinds of thoughts?" I don't want to [abuse] my own kid, but my kids weren't circumcised and you have to clean them or they'll get an infection. I talked to a nurse about it and she said, "You have to clean it because if there's stuff in there because they can get sick". I felt better having somebody telling me that instead of me doing it and feeling like a pervert.

When my first son was born, I felt that somebody loved me and that I had somebody to love, like healthy love. I was going to look after this baby and nobody was going to touch it; nobody is going to do the same things that were done to me. I was also kind of bummed out about not being able to go out or doing anything... just staying home

and being a mom. But I found that I got to explore different things. I went back to school and I finished my grade ten and then ... I don't know ... all of a sudden I just turned to drugs and my mom took my son. I was homeless for three years and then I got pregnant again. I had my second son in Grande Prairie and I was doing good. But then, I came back to the city and it started all over again ... the drugs and all that. My mom took that son too. Two years later - I had a miscarriage.

I was in a treatment centre at that time. After I completed treatment centre I really focussed on recovery ... but then all of a sudden it sidetracked. I was on spring break from school and went with another guy and went back to the same things ... back on the street and doing drugs again and here I am.

It seems that hard drugs are my best friends

I am pregnant again and just finished another treatment program. I am feeling confident now, but the more times that I've tried to quit drugs the harder it is for me to quit. It seems that hard drugs are just ... we are best friends practically. They are all I have known for the past eight years although I quit for my pregnancies. I quit cold turkey and with this baby and I'm finding it really hard. I am struggling every day. I try to write things down about how I feeling and stuff but it doesn't work.

Last time I went into treatment centre I wrote fourteen poems related to addiction. Letting go of things is hard for me because I don't know how to let things go ... especially with the abuse and stuff. I don't know how to let that stuff go. I can't ... I don't know how to deal with it and I know that I can't do it all myself. I am tired of stuffing all those feelings in ... it is not healthy for me and I know it. Its what has made me unhealthy and you know it just ..., it sucks... I don't want my kids to suffer because I'm suffering.

I learned in the treatment centre that 'hurt people hurt people' and I don't want to hurt anybody else because I'm hurting ... especially innocent children ... You know like, maybe hurting their feelings or something. I was verbally abused and I don't want to do that to my kids. They are my kids and they are like... they are my world. That's why I quit drugs and that's why I am looking forward to having this baby too - so like all four of us can be a family and we can get on with our lives.

I want to do different things. I want to go back to school and take my social work degree and have a healthy lifestyle. Sure, there won't be a father, but I think it's okay to

be a mother and a father at the same time. I try to find support ... I go to a parenting group and a twelve-step group if I can get my grandma to baby or other family member to baby sit for an hour or two. Sometimes they have childcare, which is good because I have my three-year-old during the day; my other son goes to school. Sometimes I just stay home and read literature... that kind of helps me heal.

I don't want to give up my kids anymore ... I want to be there for them

I take my kids places, even though we don't have much money. I take them to like the Friendship Centre and I am trying to teach them new things, healthy things. I colour with them or watch TV programs ... I try to be the mom that my mother wasn't. My mom was hardly around and that drives me to do things differently. I see some of her traits in me ... like never being home. I don't know... I think she took away my childhood so maybe I was trying to take it back by giving my kids to her and taking off. But that sucks, you know? Because then they miss out on me and they going to end up being hurt. So that's why I want to change. I don't want to give up my kids anymore. That's just, not right... I want to be there for them, you know?

That's why I kind of feel better about having this baby because I'm getting things out. I'm not keeping things in because I know if I keep my feelings and of this other stuff inside, I'm gonna turn back to drugs again, and I don't want to do that. I don't want to miss out on this baby's life too. I want to be there for my kids.

In my culture, a baby is a gift... you need to keep it nice and whole

When I find out I am pregnant, the first thing that I do it to make an appointment with the doctor and I always go to the Health for Two Program[15] or whatever program there is where I'm living. I take vitamins and try to look after myself because there is another life - another human being involved. In my culture, a baby is a gift. The eagle is the highest thing to the Creator and if we are 'chosen' we are given an eagle feather and that's what a baby is like. You have to look after it; you can't like ruffle it, or damage it. You need to keep it nice and whole... My son wasn't born that way, he was born healthy but he had pneumonia when he was a month old. They thought that he had cerebral palsy and he was tube-fed for awhile but now he's healthy and can eat normally ... I felt that

[15] A local high-risk, outreach pregnancy support program.

that was my fault, you know, for not quitting drugs for two and a half months before I found out that I was pregnant.

I want to feel in control

With my first son, I went to Lamaze classes. I went to the classes by myself, but when I had my son, my mom was there. With both my kids, I was induced because I was overdue. My first one, he was stubborn. They put in this thing - I don't know what it is but it is supposed to open your cervix. It came out forty-five minutes later and still no contractions, no labour pains, nothing ... The next day, they broke my water and put me on the drip and then the labour started. I was in labour for twenty-three hours and I had my son at eight o'clock in the morning on July 24th ... he was nine pounds ... just huge.

It hurt. It was like a pain and a half! I thought, you know, carrying around a baby was bad enough... but it only took me two pushes to get him out. I watched The Baby Story[16] *and all that stuff on TLC*[17] *to kind of get a feel of what it was going to be like... but then I could never really know what it would be like... He had really wide shoulders - like a football player - when he was born. I was given every drug there was ... epidural, gas, Demerol and Morphine.*

I didn't have a natural labour, like having the contractions or anything at home. I didn't have my water break, nothing. It seemed like the doctors and nurses controlled my whole labour. I want to have a natural labour with this baby because I ... I want to feel in control. With my second one, I had to go to the hospital and be put on a drip. I had gas, but that was about it ... I didn't want any other drugs – no morphine - nothing. I kind of a had natural labour with that one.

It hurt but I felt good. It was ... it felt easier and the time was shorter. I was in labour for eleven hours and yeah, it seemed like it was easier. It... kind of felt more empowering I guess, because birth is supposed to be a natural thing. I kind of felt that I had missed out on the first one, because I never got to feel anything.

This nurse was telling me to push and I didn't know how but then they taught, so when I had my second one, I knew when to push because I could feel the pain. So I kind

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[16] The name of a reality television program
[17] The Learning Channel

of felt more in control in that sense. My second son was eight pounds. I want to have a healthy baby this time and I'm not taking any drugs this time either and....

It's weird because my doctor is a woman but, I still get flashbacks

My doctor is a woman and I am going to be delivering at the Grey Nuns Hospital. I have never told her that I was abuse in the past; I just told her that I don't want male doctors – she has never really asked me about being abused.

I think it's important for doctors and nurses to know about abuse because it would make them understand more about a person's health, like their emotional health especially. If you are a rape victim in the hospital they always ask if you want mind having a male nurse or male doctor ... they can understand that. But if a person has grown up with abuse, they don't ask you the same questions. I think that if a nurse or someone would ask, it would be comforting because its hard lying there getting flashbacks because some person is prodding you ... Its weird because my doctor is a woman but, I still get flashbacks. I have to keep telling myself "It's my doctor. It's okay".

I feel better about myself because I look after myself better when I'm pregnant

I think it would be hard to be pregnant if you didn't want the baby ... it wouldn't be a good experience. I've never felt that way with my kids – never. I feel good when I'm pregnant. I feel like, I feel better about myself because I look after myself better when I'm pregnant.

I am 23 now and I want to have more kids when I'm in my thirties or something like that. I don't want to be with a guy right now – because I need to get healthy. I want to grow with this baby for at least a year and then maybe find a partner that'll look after me and my kids. I want to find someone that's healthy, someone who just doesn't want to get laid and then leave ... I can't do that anymore. In recovery they recommend that you wait a year until you get in a relationship, so I'm trying to wait at least that long. Yeah. I can't have my kids around an abusive person – they could look like a Ken doll and then turn into like this ugly, weird like gremlin or something. I don't think you can tell an abusive person by looking at them. I want to find someone who is emotionally balanced ... healthy. There aren't too many men around my age and that are like, looking for a girl with like three kids, you know? But that's okay. I am ready to just to live my life and be with my children.

My first abuser has apologized to me. He said, "I am really sorry for what I did to you when you were small". When I asked why he did it he said, "I don't know. I was sick". It was healing. It was really made me feel better, because when I was a kid I thought, "This is my fault. Why do I keep doing this to myself?"

Response-Ability to Motherhood

Elly[18]: I Was Not Ready to Be a Mother

I felt like it was some kind of invasion

I was pregnant twice, but had only one live birth – my son Thomas[19]. The first time I was pregnant was terrifying. Even all these years ... forty-some years later ... when I think about it, I am appalled for that young woman. I had no support from my husband, my family, my doctor – it was like living in a vacuum. I felt totally alone in my pregnancy. By the same token, I was so alienated and dissociated from my body that, had I been given information, I am not sure that I would have been able to take it in. Sometimes one is passive because that feels safest.

My prenatal visits were all very brief. The first one was "Yeah, you're pregnant; you're due on such and such a date. See ya". For all of them, it was rarely more than five full minutes from the time I crossed the threshold until I was back on the front step. There was never any time for questions and he certainly did not offer any information. This was a time when there was little information available to women about their bodies, so I really had no idea what was happening to my body or about what to expect or even what questions to ask. I felt like it was some kind of invasion.

Later I learned that the baby had died somewhere around twelve weeks. I carried it for another eight weeks. I knew that nothing was happening; there was supposed to be movement and there wasn't any. When the doctor asked, "Have you felt any movement?" I said, "No"; he said, "Oh well". He didn't even check and I did not even know enough to be alarmed. Then somewhere around my twenty-first or twenty-second week, I went into labour and the doctor told me to go to the hospital to be checked out. It was my first hint that something might be wrong.

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[18] Elly Danica gave her permission for me to reveal her full name. She is a well-known Canadian author who lectures internationally. Her books *Don't: A Woman's Word* (1988) and *Beyond Don't: Dreaming Past the Dark* (1996) tell her stories of childhood sexual abuse and healing.

[19] Pseudonym

My husband dropped me off at the front door of the hospital. I was in total terror and still did not know what was going on. Eventually one of the hospital staff came to me and said, "He won't be in until after his golf game and then we'll see what needs to be done with you". I seriously thought I had gone to hell. By the time he did arrive, it was clear that there was no heartbeat and that I would have to expel this dead fetus.

I seriously thought that I had gone to hell

My labour set off a whole series of flashbacks, for which I had no context. I was still in denial about my abuse. I seriously thought that I had gone to hell. As things progressed, an older nurse came in and sat with me. She was very good. She tried to settle my panic and talked to me about what was happening. If it had not been for her, would have lost it completely. I was very close to being in 'screaming maniac' mode.

They wrapped up the fetus and removed it, really quickly ... they said it was a male, but I never saw it. I guess the idea was that it was dead so, off it got carted. Looking back on it now - and even back then - I remember thinking there should be some sort of burial ... something. I never saw that baby, the first one.

I was not ready to be a mother

When it was all over, I was extremely grateful that the baby had died. I had tried to tell people all along that I was not ready to be a mother, but I was not given a choice in the matter. You were married, your husband decided when to start a family ... he decided that I would have children, and on we went.

The whole experience left me in shock for a long time. My in-laws and my husband became very concerned because they thought I wasn't grieving appropriately. Of course, I was dissociated, so it was not as if it was a real baby... my baby. It was just something that happened. It was something that just happened, but it was not connected to me. It was as if it was somebody else's baby. It was not part of me or my body or my consciousness. I felt no connection to that baby whatsoever.

From this distance grieves me now. I grieve for the young woman that I was, and how - you know - and how terrified and alone I was then; but at the time, I was grateful. That baby was born on February 3. I think about him every year and, on occasion, I talk to Thomas about his brother. That baby is more real now than it was at the time, but I am a lot more connected to the world than I was at that time too.

Eventually my husband and my in-laws decided that I needed to see a psychiatrist, who decided that I had an issue with my mother; I have no idea how he came to that conclusion. He also decided that I would stop my 'nonsense' if I got pregnant immediately. Once I tried to tell him that I had a problem with my father, but he completely dismissed it. When I said that I did not want to be pregnant, that I did not want any children, he read me 'the riot act' about my wifely duties. He even brought my husband in to tell him to do whatever was necessary to get me pregnant again as soon as possible. If I refused to cooperate, he said that I would find myself in an institution. That psychiatrist basically gave my husband permission to rape me until I got pregnant, which he did. So there I was again, powerless.

I felt the presence of a real baby

When I got pregnant again though, something was different. Thomas was born in August, so it would have been sometime in the winter - late February or March, something like that - I felt the presence of a real baby. I remember having these inner conversations with him like: "Well, you know, I have nothing to give you... I'm scared to death of hurting you". I was very anxious about what I could do to a baby because I was so mixed up and distraught on so many different levels. At some point, there was – it was almost like there was an answering consciousness – giving me a strong message that everything was going to be okay. I settled down and I started to think about whether it was a boy or a girl and started to engage with my pregnancy in a way I had not the first time.

I had a different sense of my self

I started paying more attention to my body. Things like, if I ate such-and-such, I felt better than if I ate that... Coffee would make me puke - I had always said I could never do without coffee - well I managed to do without coffee. So I was much more in tune with my physical self. I did not have a whole lot more information, but I had a different sense of my self. I think that I had a growing confidence in my ability to bring this baby into the world. Beyond that, I did not have any confidence that I could actually look after a baby. I made a pact with myself that I would carry this pregnancy to term, but as part of that pact, I would never be pregnant again.

As I got closer to delivery I started to, you know, do the 'layette thing' and get a crib ... all that kind of stuff... But it still felt like a trap. The trap was that I would never, ever be able to do anything with my life except have children on somebody else's agenda. When I was finally ready to have a child - sometime in my late thirties – it was too late because I had made some decisions that made pregnancy impossible. It was more than a decade after my son was born that I felt grounded and ready for motherhood ...but I lived my young womanhood at a time when women did not have those kind of choices.

I remember when it first went around the military base that I was pregnant. Several women phoned me to say, "Well finally, you'll give up all this other nonsense". The 'other nonsense' was that I was starting to explore my craft and taking a university course by correspondence. I lived in rural Ontario and the women around me on the base thought I was absolutely crackers; they seemed to resent the fact that there were things I wanted to with my life that didn't include having a whole gaggle of kids. It was as if I was turning my back on womanhood or something.

My second labour started in the early evening. There were strong pushing sensations so I had no doubt that it was labour. I was surprisingly calm and got my husband organized so that he could toodle me off to the hospital. My husband stayed with me this time. He stood at my head, while the hospital staff was at the other end giving me directives. At one point, I can remember saying, "Well if you think it's so damn easy you do it. I quit!" they were not impressed with my language and someone said, "We won't have any of that in here". I remember thinking, "Hmm, I wonder if they'll throw me out?" My son was born around two-something in the morning.

Maybe I'm dangerous to him and he knows it

When I held him, he felt like a complete stranger, although I don't suppose that's unusual. I couldn't really believe that this child had come from my body. In the next moment, I knew with a sharp clarity that if this kid was going to have any hope of not being damaged, I had to get the hell out of there. Within twenty-four hours of giving birth to him, I decided that I was going to leave him and then I spent the next twenty years saying goodbye to him. It was not pretty, but I knew that I could not hurt this child. My choice was to stay and risk harming him or leave and hope that he had a chance. A few days later, I left the hospital with my plan very firmly in mind.

I could not hold him to feed him; he would not... he would not drink from his bottle if I held him. He would squirm, wiggle, and push the bottle away, or he wouldn't open his mouth, or wouldn't suck. There was just no way he would take his bottle from me. If I propped him up on the sofa and didn't touch him at all, then he would drink from his bottle. It worried me that this baby that didn't seem to want me to hold him. I thought to my self, "Maybe I'm dangerous to him and he knows it". I don't know what I was communicating to him – I certainly didn't hate him, that's for darn sure. I knew I was the problem.

My doctor told me that it would be extremely dangerous for me to nurse my son, because during my pregnancy I had some lumps in my breasts. He told me that if I nursed my son, that I would get cancer....and of course not knowing anything, not having anyone to ask, and he being the doctor... I didn't nurse my son. I wonder now if things would have been different for him and for me... whether I would have been able to ... whether he would have nursed....

I could think of him and stay grounded

I cared for him until he was two and then I left him with my husband. I felt that by then my husband would be able to cope. There were childcare arrangements available to him and I knew that my son would have a chance. I was becoming more and more - I would not say crazy - but I certainly was not in a good place. I had a meltdown related to the abuse history. I had been prescribed Valium when I was fifteen years old because of my 'bad attitude' toward my father. I stayed on it until well into my thirties, continuously given bigger doses because of resistance to 'my wifely duties'. Sometime in my mid-thirties I decided that I had had enough of this dependency and I basically went off it one winter and I don't think I've ever been loopier.

The thing about having a child though, is that somehow through all those very, very difficult years I could think of him and stay grounded. Whenever I thought of suicide - I had promised myself that I would see my Thomas before I killed myself – I would spend time with him and somehow that pushed the thoughts of suicide away.

***It was gut wrenching to live without him.** I*

It was gut wrenching to live without him. I was at university and stopped telling people that I had a child. Many people I knew at the time had no idea I had a child,

because every time it came up and I owned up to the fact that I had a son that I was not raising, people would call me a monster. They could not see that I was doing this for both our sakes, but especially for his. I still get choked up and teary talking about it.

My reproductive years were a minefield to navigate

I thought that the only way I could have any power was to give up my reproductive system. I don't believe that anymore, but it is certainly how I saw things in my twenties. I wish that I had had the power to decide when I was going to have a child, because I think if I had been able to do that, I would have been a very good mother. I really love children, but I was not capable or ready when my husband and a psychiatrist deemed it the 'right time'. I was not ready but I could not get anybody to listen to me.

My reproductive years a minefield to navigate and I was glad when I knew they were definitely over. As long as I knew that I was capable of getting pregnant again, I felt like a sitting duck. I could control whom I choose to sleep with but I had no protection against rape... and rape had already been in my history. The idea of having a child ... you know that another rape that might happen... I couldn't face it.

I have actually spoken with my son about this – that the decision to have a child takes two people. It is not when you are ready and when you want to have a child. It is when you and your partner are ready. As I said to my son, "You are not carrying this baby. She is. You must not pressure her to have a child if she is not ready. I do not care what her reasons are. If she says she is not ready, she is not ready. She will know when and if the right time for her to have children". I also think we need to respect that the fact that not all of us may choose to become parents. We need a heck of a lot more supports around pregnancy and birthing than were available to me. I think to a degree those exist now, but I wonder if they exist only for middle class women.

I am going to be a wickedly engaged grandmother

My son and I have talked a lot about why I could not raise him. I think that he believes that I did the right thing. We both wish it could have been different, but it was the right thing. He is not broken ... he is not broken. He has sorrow; he sometimes feels badly about the fact that I could not be there for various things in his life, but he knows that it was the best option available to him and I at the time. I can remember once when he was about fourteen years old, we had been at one of my sister's, - she is wacky. He

watched her with her children and when we got back to my place, he said, "It would have been like that, wouldn't it?" And I said, "Yeah, some version of it", and he said, "You did the right thing".

I have a young friend who just had a baby - we have been friends since before the first baby - and the amount of information she had, the research, the questions she could ask ... the support she had around her... I was so envious I could not believe myself. Oh and then when she gave birth, she had this baby. She has a connection to her baby that is completely different from what I had. I love spending time with her... I really enjoy watching her with her babies. It gives me a great deal of pleasure and comfort to know that I could have done that had my situation been different. I could have been that in love with my baby. I could have enjoyed, you know, all the pleasures of having a small child. I am going to be a wickedly engaged grandmother. I have already warned my son, they will never get rid of me!

Chloe: I'm Not Supposed to be a Mother, I'm Just Not Worthy of This

The abuse never leaves you; it is always a part of you

My family was living in Africa and when I was a teenager, I came back to Canada to live with my grandmother – my mother's mother. That's where I was abused by my uncle - my mom's brother. He's was very controlling and tried to put it all on me ... perpetrators do that. They try to distract you so that you don't think it's their fault at all. I finally did stop it three years later, when I was able to talk about it. I told one of my best friends that, you know, that something wasn't right and that something had happened. I told him to take me to the police station to fill out a report. During that time, I had a lot of guilt. I thought, "Maybe it is my fault", "If I hadn't' done this, then it wouldn't have happened", and so forth.

When I told my family, everybody supported me except for my grandmother; she kicked me out of the house and said that I shouldn't make up such stories and that things like that happen, you just live with it. I got so mad because she did not believe me that I decided to take him to court on my own... my mom and my aunt supported me... even my grandfather understood. When I took my uncle to court ... I felt better ... I felt that justice was served, because he actually did go to prison. Going to Court also made me feel better, because one of his big threats was, "If you tell anyone, your grandmother will get

mad, I will go to jail, and nobody will believe you". Well, everyone did believe me – except her. Yes, she got mad at me, but his threat did come true in that he did go to jail, which made me even happier; it made me feel like I was in control for once. Even so, the abuse never leaves you; it is always a part of you.

Its one of the reasons why I don't want our son to go to daycare ... I understand that I will not be able to have control over his all of his life but ... The first place I phoned sent up a 'red flag' for me because it was a woman who runs a day home and her adult son lives there. He is 21 years old and apparently runs his own business from home. I thought, "To be that young and run your own business from home", it just didn't sit well with me. In the end, I actually did not go meet the people ... it ran through my head, "I hope these kids are safe in that home".

Everybody seemed to want life to go on as if nothing had changed

After the trial was over, everybody seemed to want life to go on as if nothing had changed. It was like, "Let's just forget about it and move on" ... even though I can't forget about it. My aunt has dealt with lots of troubled kids and I do talk to her from time to time. She says, "Exactly. It cannot leave you; it will always be with you and you have to learn to deal with those situations". So she understands. My mom chooses to remain angry and will not go to counselling or to get any help ... It is very rare for her to be able to talk about it because she feels so guilty ... she says she is so sorry that she sent me here. My parents stayed in Africa and three days after I got here the abuse started... If I were in her shoes, I would probably feel the same thing. I have told her that she has to go to counselling; she can't be upset with me because something happened to me. She needs to take care of it because it puts pressures on me, you know? She cuts him out of pictures; she insults him. I've told her, "I don't want to hear it. I've gone through a lot of stuff and I have to move on, so don't take me back". When she talks about him like that, he's in control again and we can't let it be that way. We have to surmount it and move on. Like I say, it's never going to leave me, but you have to face the world and you can't pout about it all your life.

It just keeps coming back to me though ... whether it's seeing someone who looks like friends of the perpetrator or - when I still lived in the same city - I would run into my uncle from time to time. When I did, I would get angry and think, "Well, who are you to

continue your life as if nothing is wrong when you've affected me for the rest of my life?" I know I need to move on. If I don't, then he's still in control... but at times it gets to me and I just can't seem to move on.

I'm not supposed to be a mother; I'm just not worthy of this

When I found out I was pregnant ... I was excited and then right away I said, "No. I can't be. This isn't right". I do believe that my reaction relates back to being abused. I was abused when I was 14 and it put me back in that place. I felt ashamed and that it was my fault that it all happened. I felt like a little kid, like a young teenager who is pregnant and should not be. That's pretty much what I felt like. Another big part of that was that my baby's father was not sure whether he wanted to be a father at the time, so that did not help; that put a lot of stress on me.

Through pregnancy I ... I don't know that I would say that I was depressed, but I was not excited about it ... about being pregnant even though it was something that I wanted all my life. I have cysts on my ovaries and was told that I might have to have help, getting pregnant ... but I did it on my own. I should have been ecstatic ... I ... lots of times I wished that maybe the child would not survive. Lots of times I felt, "Well I almost hope this child just doesn't make it", just to prove everybody that you know, I'm not supposed to be a mother; I'm just not worthy of this. I felt that I don't deserve to be happy ... I don't deserve to be a mom, even though I wanted to for so many years.

When they found out I was pregnant, people said, "Oh, you're going to be such a great mom. You are so patient". I thought, "Oh yeah, right. You're just saying that just to make me feel better". Even when he was born and they put him on my chest, I didn't really even feel anything. It just felt like, "Who is this child on me?" ... I thought the minute a child was born that you bond ... that you are supposed to feel such excitement ... I wondered what the heck was wrong with me. I didn't say anything to anybody, but I was sure the doctor saw it in my eyes when he put the baby there for me to see. They didn't leave him there very long; they took him away as if to say, "Who are you to not enjoy your child? We'll just take it away and do the stuff we need to do".

I was more connected to my body

At times during my pregnancy, I was more connected to my body. Like when I actually felt the baby move at sixteen weeks. That was early. I was very in-tune with the

baby moving, maybe more so that other people. I had a friend, who was not far behind me, and she did not feel very much at all and she has not been sexually abused. I just found it very interesting that even though I was disconnected from my body, when the baby moved, I felt that a lot. One day I was driving home one day and felt the baby drop, and I thought, "Oh my goodness. Can I ever just breathe so much better! What happened?"

During the first trimester I had high blood pressure that everyone thought was because of the salt I ate. I didn't want to tell them that it was because of stress. I had to work on that - which is why I decided to go to counselling - to be able to bring down my blood pressure because they say in the third trimester your blood pressure gets worse.... Luckily it did go down. I also had extreme morning sickness up until five months and then had to be on short-term disability because I ended up with bronchitis three times during my pregnancy so, I was actually quite sick.

I went to counselling - I can't remember how many sessions ... I believe eight of them - and I decided to terminate because I wasn't satisfied with the way the counselling was going. I didn't feel that I was getting much direction or help. As things worked out, I wouldn't have been able to continue anyway because my work schedule changed. So I more or less worked on it on my own ... just like anything else, I've had to be very independent and just internalize it and try and work it out myself. That is what I did when I was abused for years. When I did put an end to the abuse I was accused of being 'sick in the head'. It was seen as my fault. I had been in a car accident that supposedly affected my nerves and changed me as a person ...

I was trying so hard not be stressed out

A big stress for me was that babies feel stress from their mom, so I was trying so hard not be stressed out. In the end that I did talk to my baby's father. We were living together and I was so upset that I wrote a five-page letter saying that I was going back to Africa to live with my family and that he could sell my things. He got the note in the morning and actually stayed home from work and talked to me. He told me that I was being ridiculous and that we could work things out. It was not that he didn't want a child; he just wanted to be more financially stable. I said, "How do you ever know if you are?

Some people who do that end up never having children because there is never an exact right time".

At the beginning, after our son was born, I felt like a single mom because he was not involved. Talking with other moms, I find that it's almost like dads don't come into the picture until the child responds more - basically around six months when they start doing more – then almost magically they become dads. It's just, very odd.

I felt like I didn't do something right

I had to be induced twice. I was eight days past my due date and they had to break my water and all that stuff ... I was disappointed that things were not happening naturally...Why did machines and people have to make this child come out? I guess I didn't expect it because when the baby dropped just after Christmas - they say with your first, after the baby drops it will be born four weeks later. I thought, "Okay good... it will be the end of January"... but the doctor said beginning of February and then nothing happened. One weekend I was sure that my water broke - they thought so too at the hospital - and wondered why I hadn't come back when they sent me home. Well, there I was two weeks later with no baby. Part of it felt like I didn't do something right because the baby wasn't coming out on its own. I made sure to do an awful lot of walking, which, actually did help, for the baby to drop. Even when I was in labour in the hospital, I made sure to keep walking, even though at times it hurt. I just said, "I'm going to do this because I'm determined it's going to come out on its own and naturally".

The one thing that did annoy me was every time I told the nurse that I was in pain, she would turn up the drip so that it hurt some more. I thought, "Maybe I just shouldn't tell her anything because who is she to decide to make me hurt some more?" When I went in to the hospital, I did not want an epidural and I did not want an IV because I've had problems with IVs before, but it turned out that I had both. We had taken prenatal classes and I had decided that I may as well just suffer through the pain but at one point I said, "I can't do this anymore" so that's when they did the epidural even though I felt so strongly about not having it.

I was in labour for three hours – three hours of intense labour and then it was forty-five minutes of pushing, which actually did not even seem that long to me. It seemed to go by very quickly for me. I did ask for a mirror so I could see how I was progressing

and that really helped me along. I am a visual person and when I saw the head it ... what's the word? Not encouraged, but made me feel better that I was actually doing something right.

I didn't let myself feel anything

Even after we came home, I felt like I was babysitting more so than his mother. It actually took me a good couple of months before I felt that I was actually a mother and not just looking after a child, someone else's kid. When you are abused, you tend to separate yourself from your body. I believe that is what I did. I didn't let myself feel anything when I was abused and I did the same thing when I had my child, I didn't let myself feel all the joy ... I know that people who have not been abused may not feel excitement about being a mother ... but I still think, for me, it was connected with being sexually abused. You are basically out of your body.

He can make light of situations, which makes me feel better

My doctor is a gynaecologist-obstetrician and our relationship is good. I don't keep anything from him. He's very good at ... he's not a jokester or a comedian, but at times he can make light of situations which actually makes me feel better when I come out of the office.

It didn't cross my mind at the time to tell him about my abuse. Like I say, a lot of times I just try to put it behind me. I don't think it would have been fair for him to ask. I feel that if the doctor asks then it kind of puts the person in a corner and they might turn sheepish or might decide never to come back. A form to fill out might be better because some people feel better writing it on paper.

Well, it did happen, so the reality is that we need to deal with it, right?

The other point I would like to make is that not everybody is trained to deal with someone who has been sexually abused. Asking about it may not turn out because if someone is very empathetic and says, "Oh, I'm so sorry that happened to you", that might not be where I am right now. Where I am is, "Let's figure out a solution as to how to help you feel better right now", not, "Oh, I'm so sorry. I wish it hadn't happened to you". Well, it did happen, so the reality is that we need to deal with it, right?

Debbie: It's Hard and the Most Incredible Thing You Can Ever Do

There was a 'yes' to get pregnant

The first time that I met my husband – his name is Carl[20]*– the first time I met him I completely, like I completely fell in love with him in a way that I had never done before... I said you know this is one of the finest men I've ever met and I want to hang out with him. That didn't happen until one day – it was his birthday – we spent the day sitting on his couch, listening to music together... I just gave my heart to him. We got married right away and a week later, I got pregnant.*

All I knew was that there was a 'yes' to get pregnant. Like I ... there was a space ... it was like, I could do this. I'd never really wanted to... I used to have a bumper sticker on my car that says, 'Motherhood is optional'. I was already 38 and I didn't know if I was going to get married and have kids. It was like, "Wow. What do I do now?" There was a lot of, you know, there was a lot of joy through it and a lot of fear ... and ... this knowing that my whole life is going to be completely different and not even being able to imagine what that would be like.

Why would you want to have a baby in a hospital?

When we went to the hospital for pre-natal classes, it was awful. All the instructor talked about was epidurals, forceps deliveries, breach deliveries ... When I asked if I could squat to deliver the baby she said no, I couldn't, that I would tear; they didn't allow it and that you had to lay down and with the stirrups. I said, "Let's go, Carl, right now, we're out of here. This is too crazy". I would never have a baby in a hospital.

I'm so surprised that women will try to avoid the pain of childbirth; that they're afraid of birth. It's like we've been so disempowered to believe that we can't birth a baby by ourselves ... we can! It was the same thing with my daughter. I would have had her by myself in a second but I had a midwife for safety ... to be safe.

I had a girlfriend when I was living on Saltspring Island, who had both of her babies by herself, with her husband in the forest, in a pool. She was my mentor. It was like, that is the way babies are supposed to be born. Like, why would you want to have a baby in a hospital? Why would you want to have a baby anywhere except, you know, in the forest or in your home, or in an intimate environment – that seemed to me the way to have a baby.

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[20] Pseudonym

So I never got a midwife. I went to a doctor because I knew that, you should to make sure that the fetus is growing correctly and everything. I didn't know how I was going to birth the baby, I had no idea, but I kept talking to people. I'd say, "You know, I really want to have the baby by myself" ... everybody thought I was completely up the wall. They thought I was really crazy. The bottom line for them was that it could be dangerous for the baby and I finally came to see that. So when I was eight months pregnant with my son, I got a midwife and I told her about what I had wanted. She was all about 'bonding with your midwife' and stuff ... but I was like, "Well that's all hocus pocus, I'm just having a baby here. This is not a big deal", right? For me it was kind of strange to think about this woman as a midwife, she didn't fit into the picture somehow – this was something between my husband and me. It was like a personal ... very intimate thing.

I woke up one morning, it was a Sunday morning at six o'clock in the morning, and I just like jolted out of bed. Everyone had said ... the midwife particularly, but most people I had spoken to had said, "You'll know when you're in labour because you'll just know it"... and sure enough, I knew. I'd had some contractions and stuff going on, but that morning I knew I was in labour.

I didn't wake my husband up for a couple of hours, I kind of lay around and walked around and had these contractions ... it was so amazing to experience what my body was doing, because I didn't need to do anything. I mean breathing helped... I had taken a few prenatal classes but I stopped going because it was so fear-based. It was like my body knew how to do it all by itself. It was so wonderful to just to let my body birth this baby.

At eight o'clock my husband got up and we went out to some friends' house for breakfast. I was having contractions ... at one point, the woman asked how far apart they were. When I said about two or three minutes, she said, "You better go home!" It was eleven o'clock when we left.

I phoned the midwife when I got home and she showed up about a half hour, forty-five minutes later and set up a birthing pool. Hard labour had started by this time, so I was really... it's like the body just knows what to do ... when you go through the transition period you start shaking and maybe I threw up a little bit ... it's so intense and

everything is heightened. But it was really wonderful because we set up the birthing pool and everybody in the rooming house came to the birth. I crawled into the pool of warm water and it was the best ... to let my body go into the water like that and float when you're in such pain – it was just heaven! But it was another six hours before my son was born. I was in labour from six o'clock in the morning until six o'clock in the evening, so it was a full twelve hours of labour, quite hard labour.

Of course, you get to the place, the ring of fire, where I was pushing his head out ... but once his head was out then it was fine. It was amazing, because all these people that were there - I just loved them - they were all my friends and everybody held my hand and supported me. The midwife didn't have to do anything because I had all my friends there! It was so wonderful!

My husband was there, but I found that it was my women friends were way more valuable. Somehow it shifted my relationship with each one of them. It was almost like going back in a train or something ... going back in time and experiencing the history of women ... like doing something really, really old, and really, really natural. I loved it. It was scary too, because it was the first birth.

When Daniel[21] *was born, my husband caught him and put him up on my chest. We didn't cut the umbilical cord right away, of course. We let him stay there for a while and we rubbed him and he suckled and we floated him in the water. He barely cried or anything; he was very still and very quiet. My son is visually impaired, so it's kind of interesting because he was very quiet, almost like he was observant; in retrospect it seems like he was listening. I called him a golden baby because he was; he was quite golden and quite luminescent. There was something really special about his birth and about him.*

Somebody had baked a cake, so we had a birthday party for him ... it was really lovely and then a bunch of our friends came over. We passed him around and I rested. The only thing we needed the midwife for, which was completely valid, was for stitches, because I needed to have a few stitches. I had almost no idea what to expect, because

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[21] **Pseudonym**

even though I had read about birth and I had watched the birthing videos ... until it was actually happening to me I could never really knew what to expect, I just let it take me...

It's like you can see part of you in them

So yeah, we just had a nice party and Carl's family came ... all our friends came. By nine-thirty, ten o'clock at night I was completely exhausted and went to bed. Afterwards we had a good week of quiet. Some very dear friends brought us food every day and so I had people helping, you know, cook. I had a lot of good support, which is nice. I didn't name him for three weeks; I couldn't... I could not put a name on him. It was like, how can you put a name on something so pure? ... I didn't put clothes on him either, I just wrapped him in blankets and little cotton diapers. I'm quite alternative anyway, right; like I'm not a mainstream kind of person but I would never have known that my birth would turn out that way. I'm really grateful for knowing that woman that I knew on Saltspring Island because she was like my, my lighthouse. Had I not known her, I might not have had the births I wanted.

I look at my two kids now and it's like, I will always know them. There is something in them that I think you always see. I understand now why my mom says to me, "You'll always be my baby!" I know why she said that, because they are always your babies. It's not that they are always babies; it's that there is something inside of them that you can see as a parent and that is what makes them your special children. You always love them because you know that intimately in them. It's like you can see part of you in them.

The razor's edge

As a pregnant woman, it's like you have this being inside of you and you can relate to it, but you can never know what it's like until you actually hold that little baby in your hands; and then you go, "Oh my God! This is the magnitude of what's happened here, this is what we've created". So for those nine months, the gestation period, I was just going through all kinds of different upheavals and letting go and seeing myself in different ways. Your body of course changes ... thankfully had some really good friends that - not a lot of them were parents - but they all really supported me and really loved my husband and what we were doing.

I went through lots of things when I was pregnant. Like resenting being pregnant because I could see that I wasn't going to be able to do things. I had to quit my job. I had never relied on a man financially and suddenly, I was going to be supported by my husband ..., that was shocking for me to think about that. It was like I had started losing all of these little plugs and my life started getting holes, you know? I realized that I'm not going to be able to just get up and go ... I'm not going to be able to do the things that I normally do ... have a job, go out with my girlfriends when I want. I started seeing that my life was really coming to an end and that my life was going to be for someone else's for awhile. My husband was able to go to work and do all his normal stuff and have a normal life, while I was losing more and more of mine ... I couldn't bend over any more ... I couldn't sleep at night. My life was slowly being taken away and then when you have your baby; it's like, "Whoa! Now I really can't just get up and go!"

Because we were newly married, the first couple of years of marriage were pretty hard. We were just settling into all of these different ways of life and you barely know each other. He's five years older than I am – so I was thirty-eight and he was forty-two when we got married, right? For him to settle down to having a family, that was, that's been a big deal for him ... for both of us. It has been a really big settling.

It was like a two-edged sword. In one minute it was like, "Oh my God I'm going to have a baby!" ... and in the next it was "Oh no! I'm not going to be able to do anything any more". There were flip sides to everything. It was more intense when I was pregnant with my daughter because I saw the shackles. It was like, "Holy mackerel, now my life is going to be even more weighted".

In India I was a sardhu - it's like a monk in the Hindu tradition. I gave my life to God and I thought that was a hard life. We had strict disciplines in eating, and bathing, and working, and all of that stuff. But this is way harder – it was the 'razor's edge'. To begin with, it's in the world and I've never really been one to be in the world. I've always kind of lived on the outskirts of the world - that's probably why I've always been a hippie or whatever, right? So it's the biggest thing for me was becoming a 'normal person'. My dreadlocks are gone because if you don't look normal in our culture, people stare at you, they judge you, and they criticize. You have to fit into this society. It's best for your children, for yourself, for ease. If I was taking Daniel to school, and I was, you know,

dreadlocks would make things really hard, I'd be very isolated and maybe ostracized. That's definitely been a big part of my life, being on the outside.

This place feels more like home to me now

I've always felt like I've never fit in; that I've never belonged. That's why I went traveling, because I thought I don't belong here and I wanted to find a home. This place feels more like home to me now. What's so outrageous for me is that it's the most normal thing in the world is to have children and a family. Like it's so normal ... but it's a good normal. You get to understand, "Oh, that's what my breasts are for", "That's why I have hips" ... it's like all of the sexual connotations of women's bodies - the curves and all of that - it's so crude in a way. Because breasts are for breastfeeding, you know? Hips are for birthing a baby!

Settling in to a relationship was huge for me. When you get married, you stay married - it's a serious commitment. And then to have a family... realizing the magnitude of the commitment that it takes ... all of the bend-ability and the compromise.

I'd never experienced a love like that

When my son was born that was when I became a mother, for sure. When I was pregnant people would say, "Hi, momma bear", but I never knew what that meant. With both of my children, as soon as that child came out and was in my arms, it was like a flower just went whoosh... it's like a flower opening so full and so wide. I'd never experienced anything like it before. It was like the love that overcame me was so – I'd never experienced a love like that. It was like, "Oh my God. This is what is meant by a mother's love'... that was when I became a mother, when I held that baby in my arms.

I knew that we were going to have another child. I knew that I wanted two and we were in a little bit of a hurry because I was 39 when Daniel was born and 40 when I got pregnant with Dawn[22]. We never practiced any birth control or anything but it was still a surprise when I got pregnant. I knew right as soon as it happened, it was like, "Oh no, brace your self!" It was the same thing – a huge letting go. I went through lots of resentment ... resentment has always been an issue in my life. I see it over and over again and I know when I'm having resentment. Its like, "Oh, you know, I need to look at this because there's something that's off here". I went through a lot of resentment because

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[22] **Pseudonym**

my husband got to work while I am staying home now. I barely get to see anybody and he works a lot of long days and a lot of late nights and that keeps the pressure on me.

Throughout the pregnancy with Dawn, I could see less of my life and less space for me.

I never see my single friends any more ... I remember too as a younger person, when friends had babies; I never saw those any more because I wasn't interested in babies. As soon as you have babies, your whole life revolves around babies and so the only friends you get to have is friends that have other children. I didn't have a lot of friends and I didn't have a lot of support ... I was alone with my son and I was sick. That was really tough; those nine months were really, really hard for me.

The world is such a cruel place

Dawn's was a really hard pregnancy. I was always wondering whether or not I was doing the right thing, you know? ... Two kids and the whole bigness of it. The world is such a cruel place, how can I raise my kids in this horrible place that I don't even like? It's like this morning dropping Dawn off at preschool and the preschool teacher is standing there with a really creepy looking man who says, "I'm supposed to be picking up a kid for the, and with the Red Arrow bus". The preschool teacher said, "There is nobody here by that name". I can see she is suspicious of him. He gave me the dirtiest look, so I stayed a little bit longer at Dawn's class because ... five months ago the school was in 'lock down' because a man came into the school and into the girls' washroom. As a mother, my protection thing is so strong ... I really want to protect them from the world for as long as I can.

It seems like I'm so unprepared as a mother

For me, being a mother is a huge responsibility take. It's the biggest thing I've ever done in my entire life, truly the biggest thing I've ever done and I suspect it doesn't get any smaller. As they get bigger they need more coaching and more guidance and you need to be there for them and be solid for them. How do you guide them through this myriad of experiences? I look at how I was raised, with such little support or anything – I actually turned out pretty good but if I had had the right support, oh my God, things could be very different. I could be way more whole than I am right now...

The only thing that I wish would have been different is that I would have had somebody <u>really tell me what it's like</u>. For somebody to really sit down before I got pregnant and talk about it ... really talk about it. I don't know whether that would have made a difference or not, but it seems like I'm so unprepared as a mother ... like how to deal with all of these things. It's funny, because I talk to so many women who will say the same thing. It's like, "I don't know how to deal with this". I feel like such a lousy mother all the time. I mean all of that stuff that happens ... I would have liked to have somehow been better prepared for motherhood. And I would like to be able to somehow give that to my children, at least to my daughter ... I will try to tell her what it's really like ... that it's hard and the most incredible thing you can ever do.

Regeneration

Jane: It Was a Rebirth for Me ... I Got to be a New Person

I had a sense that it was the right time

I was told I would probably have a really hard time getting pregnant, so I never really expected it, which is why we thought we'd travel. I figured, "Well, if I'm not going to be able to have a baby, I might as well not be able to do it later in my life". I remember it was just after the Blues Festival, which is in August, I was having a few drinks, and I thought, "You shouldn't drink when you are pregnant"- I had no idea where that came from. Then a couple of weeks later it was my sister's birthday and I felt really funny and for some reason thought I should take a pregnancy test.

My partner and I had been together for four years and had never used birth control because we wanted to have a child. I really didn't think that it was ever going happen, so the idea that I should get a pregnancy test, it didn't really make any sense in my head. But I bought a pregnancy test kit anyway and when they both came back positive I called my partner at work and asked him to pick up another one. When the third and fourth ones were both positive I didn't know what to think. I mean I wasn't excited at first; it was more a sort of a curiosity about what would happen and, uhm... I had a sense that it was the right time.

I had been living in the UK for four-and-a-half years and I had come back to do some intensive therapy with my Mum... I obviously had issues with my Mum, given that she was married to my abuser. My baby's father - my partner - followed me in June and

then a few weeks later, we found out I was pregnant. It was a happy accident. My grandmother died at around the time we found out I was pregnant, so it was really hectic at the beginning.

Emotionally, I was overwhelmed

I was really emotional during the first couple of weeks of therapy and by the beginning of August; I was having horrible night terrors about my abuser. There were so bad that I was waking up my partner; my cat wouldn't even sleep in the bedroom. I found out I was pregnant at the beginning of September. One day at the beginning of October, I just woke up one day thrilled to be pregnant. I was over the moon and it hasn't changed since then.

Emotionally, I was overwhelmed with what was going on and excited about becoming a mom. I am in my mid-thirties and we were thinking about having a baby in a couple of years and when it happened I wondered, 'Why have I waited until I was thirty-four to have a baby?' I think part of the waiting was my subconscious knowing that there was no possible way I could raise a healthy child until I had dealt with my sexual abuse or at least had started to talk about it.

It was difficult getting past my issues with authority

I had didn't talk about it for years, partly because when it started I told my school nurse and she told me that I was lying; things like that don't happen to girls like me. I was in grade five and when I went into my next school in grade seven, I told a counsellor there as well. It was a Catholic school and the response was, "Ask God to forgive you for your sins". I just thought, "Fuck all of you!" I knew there was something going on but I couldn't... I mean, if everybody is telling me that I'm wrong and that I'm lying or that it's my fault ... I mean I am twelve and I have no idea ...

It started when I was young - when I was six or seven - and so when I started being pregnant and started having to talk to doctors and nurses, I had a lot of problems because I didn't trust any of them. They were the ones who originally told me that this it wasn't happening. I sort of connected all the medical professionals with that one nurse and it's taken me a lot of work to get over that. A part of it is that my abuser, my stepfather, was really explicit about how dangerous police are. He is a refugee from a

police state and always told me, "The police are bad", so I had no ability to deal with authority in an effective way. I had no idea how to talk to them.

My medical care was phenomenal

I found a great OBGYN who said to me - because I've been very open with my caregivers that I was sexually abused – "Just so you know, this might be very, very difficult for you. Pregnancy can often bring out all sorts of issues with sexual abuse". I am really happy he said that, because I think if he hadn't I would have thought it was me going loop-the-loop. When I went for my prenatal visits he'd always ask, "Are you having nightmares" So my medical care was phenomenal.

There were times when – not with my OBGYN and his nurse – some other nurse would ask me a question and it would be difficult for me to answer because in my head I was thinking, "You have never believed me; you never listened to me". There were a lot of emotionally charged times when I'd say, "I'm only telling Dr. H.". Even though I'd had this positive experience with my OBGYN, it was difficult getting past my issues with authority.

I have a lot of anxiety

The worst part about being pregnant is that I have – I don't know if they're hallucinations or what – but I would have these things ... like at top of the stairs, I would have to stop and take a few breaths before I walk down because I've always had these visions of myself mangled at the bottom of stairs. When I got pregnant, I started having visions of getting hit by a car and having my body go one way and my fetus the other way or of someone stabbing me in the stomach to get rid of the baby because there was something wrong with me [choking up]. I have a lot of anxiety around that, and there were times when I was really afraid to go out because inside my house I could control the environment, but outside I was really afraid of what would happen to me and to my baby. That was really difficult.

The thing that convinced me that I really needed to get therapy was about three years ago when I was walking down the street and all of a sudden I felt someone come up and put a gun to my head. I saw my brains hit the wall and I saw myself hit the ground ... I thought, "Right. I need therapy!" [laughing]. I had been in therapy before, but it hadn't been very positive. I had one therapist tell me that I was a bully and that, uhm, I didn't

have any problems except for the fact that I drank too much. I said to him, "Well, you would drink as much as I drank if you'd had the childhood that I had!" So there has been a lot of stuff that I have tried in the past but, it always seemed to be that something is wrong with me. But when I started seeing people doing things to hurt my baby, I felt protective ... I still get the visions [choking up] and I don't know if they'll ever go away.

There are times when I am afraid that I am going to 'rub off on her'

When I was pregnant with Emma[23], the visions got worse. I see a lot of really graphic sexual violence, almost like a movie in my head. Although I am getting better at it, sometimes I just can't turn it off. When Emma was born and I saw how small children are - I've never really been involved with kids - I just realized how defenceless they are... I thought, "You know, that's what I was like when I was abused". It is exceptionally difficult ... I have a lot of very graphic visuals of large men's penises in small girls' vaginas and, and the mismatch there ... I have also had a lot of pain – physically - I don't know if it's phantom pain or what, but... There are times when I am afraid that I am going to 'rub off on her', that this is contagious somehow and she is going to be abused. I mean, I know it's a family thing, my Mum was abused, my grandmother was abused, and I was abused, so I have huge anxiety about it happening to my daughter.

Because my pregnancy was completely unexpected, I had no time to prepare myself for it. I think if I had prepared myself I wouldn't have the visions; I don't think I would have had as much trauma because I would have been more sort of intellectual about it. As I say that though, I think that I would have missed a lot of the joy and I don't think I would be as in touch with myself physically and emotionally. If I had been able to plan it, I would've planned it the same way I plan everything else, "How do I avoid this? How do I avoid that?" Because I'm quite intelligent, I analyze and intellectualize everything. It is what has enabled me to go as far as I have done. It also allows me to put the emotional stuff in a box.

The nurses in the hospital were horrible

I was really fortunate that my OBGYN delivered me and he sewed me up ... he stayed the whole time. My doula said that most OBGYNs leave right after the delivery

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[23] Pseudonym

and leave the clean up and everything for the nurses, but he did all of that for me. She wondered he was trying to mediate my experience ... to protect me.

Giving birth was fine, but afterward, it was awful. The nurses in the hospital were horrible. They kept trying to force me to breast feed, and it was like, "This is my body! It's my body! Stay the fuck away from me!", but they wouldn't, they wouldn't listen. It wasn't that I didn't want my daughter to breastfeed; I just didn't want other people seeing my breasts. One of the nurses grabbed my breast and shoved it in my daughter's mouth... I was horrified. I sat there and I couldn't even touch my daughter. My mum had to take her. This nurse ... I just wanted to beat her. Dr. H. made sure that my charts said that I have a history of sexual abuse and post-traumatic stress disorder. But this woman ... she's grabbing my breast and grabbing my arms and forcing me to do things..., it was like, "Get off!" There was no sort of sensitivity, no sort of softness or gentleness or anything.

My doctor told me that I was at risk for postpartum depression... And my labour was really long, sixty-seven hours long. The hard labour was only three-and-a-half or four hours, but I started labouring Wednesday at four in the morning and I gave birth on Friday at ten thirty. So I was exhausted. I hadn't had any sleep and these stupid women kept coming in and saying, "Oh, your social worker is here to tell you about post-partum depression". I finally said, "You want me to have post-partum depression? Keep coming in. If you don't want me to have post-partum depression, get the fuck out of my room and let me sleep!" But there was no sort of recognition on the hospital's part about my boundaries ... about the needs that I had as a person who didn't have boundaries for years and years and years. There was no recognition on the hospital's part that when I said, "Get out!" it meant, "Get out!" There was no recognition that this is my body, keep your hands off my body. There was no recognition that I might need time to adjust to a small baby on my breast that other women don't need. Finally, I said, "I'd like to leave". The nurses said, "You can't leave until you've breastfed". I didn't want to breastfeed I just wanted to go home. Eventually I just made my Mum get my stuff and I left. It was really awful.

Having my defences down, made a bad experience much worse

I think I was especially vulnerable because I had had such phenomenal experiences with my OBGYN and with his one of his nurses who I bonded with; my guard was down in a way that it's normally not. Plus, I was exhausted because I hadn't slept in three days ... I had just had this beautiful new baby girl... so a whole bunch of defences that I would normally have up, weren't. That being said, I don't think that what they did was appropriate in any situation, whether or not I was abused. I don't think that the way I was treated was appropriate, particularly the nurse grabbing my breast. Having my defences down, made a bad experience much worse.

Because, uhm, my Mum was also abused, she's quite solicitous and tries to please people. My baby's father was so overwhelmed with being a father that to ask him to advocate for me with the hospital staff didn't seem appropriate in some way. That was why we hired the doula - to stand up for us. Next time I think I would have her stay a bit longer. Another thing I would do from the outset is say that I am not breastfeeding. With Emma I wanted to try breastfeeding and was quite enthusiastic about it, but I don't want to go there again.

I did manage to breastfeed for a couple of days after we got home, but I stopped because, I couldn't get my milk to come out even though I had lots and lots of milk. I had a breast reduction when I was younger, with a full nipple movement, so the glands had been cut. She nursed for 3 days but it just got too painful. I had really bad blisters and she had to feed for two hours to get enough. I am pleased that she got my colostrum before we went to formula.

I am eating healthier since I got pregnant, but for about three months after she was born I had this weird eating compulsion. I ate more Save On[24] chocolate chip oatmeal cookies [laughs] in that three-month period than I think they produce in three months. I think I was angry about how I was treated at the hospital and it took me awhile to think through why I felt so uncomfortable in the hospital. It wasn't until Emma was four or five months old that I finally realized, "They had no right to touch my body like that! They had no right to treat me like that!" That realization stopped my compulsive eating thing ...

It was a rebirth for me ... I got to be a new person

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[24] Save on Foods is a grocery store chain

I knew that I was having a girl as soon as I started actually feeling pregnant. I knew it was a girl and I knew what her name was going to be. It was funny because everyone thought I was going to have a boy. They were all, "Oh, it's a boy, it's a boy", and I'm like, "Okay", and buying pink clothes and painting a girl's nursery. I knew she was a girl.

It was a really incredible experience because it was one of the few times that, uhm, nothing about my abuser involved my being pregnant. There was a sense of freedom, I felt like I was starting a life, starting my life with my baby. It was thrilling and at the same time, I had a huge amount of fear, "She's a little girl it could also happen to her and I don't want this to happen to her. How do I keep this from happening to her?" I had this real desire to always be present.

After being abused, I spent a long time not feeling and being able to experience emotions was amazing. What I was feeling had absolutely nothing to do with my abuser or my childhood; it had nothing to do with anything but this particular moment. And that was amazing, because it was one of the first purely joyful periods in my life. There was this beautiful little baby that I got to bring into the world and watch over and help grow into this amazing human being, you know? I mean I had fears and the visions, but more than anything it was just this incredible sense of joy that... There was also this incredible sense of peace. Not exactly that I had another chance, but that I can watch a little girl grow up and see all of the wonderful things that happen. I can protect her, so I can still be a part of a little girl growing into a woman safely, you know? I know I can't necessarily protect her from abuse, but I can make it so that... I can talk to her and make her aware that if it happens even once she can come and talk to me and that it's not her fault, and it's nothing she's done. Having that sense of power and that sense of protection is really big.

Another thing that happened is that I reported my abuser after Emma was born... almost a year to the day that I found out I was pregnant I reported my abuser to the police. That decision grew out of the sense of protection that I had for her. I just thought, "If I can't stand up for myself, how in the hell can I stand up for my daughter?" If I can't say, "That person has done something wrong to me", how can I ever say, "You can't do that to my daughter?" I realized that in order to be able to protect her, I had to take care

of myself too. Always too, in the back of my mind, I had a fear that somehow my abuser would find out where she went to daycare and get a job there and abuse her too ... all these weird things... So I filed a report with the police.

They didn't do an investigation because it is my word against his. It's been fourteen years since the abuse stopped and there was very little chance that it would go to trial and get a conviction. But it is important just knowing that I had reported him and that somebody in authority had believed me and that his name is on his file. In standing up for myself I was standing up not just for my daughter, but for just little girls and boys everywhere. If every person who was abused could stand up and say, "This person did this to me", then maybe we would be able to stop it, you know? It's kind of the same reason that I am here talking to you now. I don't want to be a soapbox person, but the more I am honest about this, the easier it is for me to be aware of what's happening to me and to my daughter.

I was talking to my Mum about being part of this study she asked, "What is it that's different since you had Emma?"... and I said, "I don't have time to be depressed". I said, "Emma has to eat, and nobody else is gonna feed her. Her father is at the office and you are at work and so there's my daughter and there's me. If stay in bed and be depressed all day, then nobody is going to take care of this little girl". I just, you know, I have such a thing against abusers that I have to make sure that it doesn't happen to my little girl. I have had to be a lot more responsible about how I think and about how I feel.

I was never a mother around my abuser. He's never seen me in that role. So for me this feels pure; something that I own just myself. This is separate. I feel in some ways, not rehabilitated but, what's the word I'm looking for...? It gives me a way to reframe how I see myself so that. It's such a huge break in my life; like, first you are not a mother and then you are a mother and you can never not be a mother again. I can never not be a mother again. It has really freed me because I started therapy just before I found out I was pregnant and started going through all that ... for me in some ways it wasn't just about giving birth to my beautiful daughter, it was a rebirth for me. I was ... I got to be a new person, you know? My abuser was at my grandmother's funeral - because he obviously had known my gran - and when he walked into the room, my husband walked out and I followed him. He said, "I won't be in the same room as that piece of shit". I

said, "Don't you want to support me?" He said, "Yes I do. I'll sit with you in this room with you, but if he comes in here, we will have to move. If I stay in the same room with him, I'll kill him". That was the first time I thought, "Oh! Somebody believes that what my abuser did was wrong and I don't need to keep pretending to like him". He was the first person who ever stood up for me, ever.

I'm just thinking that maybe it is not a coincidence that I hadn't used birth control for years and didn't get pregnant until I was with someone I could trust. Maybe I was holding back. I have never thought about it quite like that before. My partner is the smallest man I've ever dated. He's six years younger than me, 3 inches shorter, and 30 pounds lighter than me, and yet he's the person who's stood up for me and protected me... and I mean, I dated a guy who was six foot nine [laughs] and 280 pounds and my partner is the first person that stood up for me.

I haven't talked to him about the details of the abuse. I don't talk to anyone about the details. He knows I was sexually abused and that it went on for a long time and that's all he knows. Because, I don't ... I have it in my head that talking about the abuse with him... would somehow allow my abuser into our relationship and our life together. He takes care of things, he doesn't need to know all the other stuff... my therapist can know that. I think that I've said that he is not Canadian, he's British, uhm... he'd kill me if I he heard that ... he's English [laughs]. So that's another way that my life now is completely untouched by my abuser.

Even sex was different for me after I got pregnant. It was full of firsts - like the first time I had sex when I was pregnant and I knew I was pregnant... the first time I orgasmed when I was pregnant, the first time I had my breasts stimulated when I was pregnant, the first time I got a massage when I was pregnant – all of that... It was almost it was my virginity in some way, because it was new.

I have a whole new family

The other big piece of it is that I have a whole new family. My Mum was adopted and has just reconnected with her biological family. My Dad was adopted too - he's dead now – but after he and my Mum split up he remarried and he and his second wife have two kids. Every major person in my life has another family completely separate from me,

which in a lot of ways made the abuse worse. I was the only one that didn't have connections to a family of their own. It made me feel more alone.

My Dad ... he chose his second family over me. He and his second wife's family made it very clear that I was not as good as them, you know? I was not really a part of the family. My Dad's adoptive parents made it clear that my Dad and his kids weren't as good as their biological son and his kids. So I've always had this sense of not being anyone's first choice. When my Mum was living with my abuser – I never told her that I was abused by him – but I'd always say to her, "Mum, why can't it just be the two of us? Why can't it just be you and me?" I figured if I could just convince her to get away, then I wouldn't have to keep trying to tell people or else it wouldn't matter if people believed me because I wouldn't have to keep trying to tell them.

When I was younger my mum was fragile and we did not have a very good relationship. I think that if I hadn't left the country, we would be speaking now. But going away- having had that distance and her being able to come over and visit for a week and then go away – we are now at a point where we have a really good relationship. When my Mum and Dad got divorced, I didn't see my Dad very often- he didn't even show up for my birthdays, Christmas, or anything. I think that I was afraid that if I told my mum, she would go away too. As a child, I remember thinking that couldn't raise my self and I had heard what it was like growing up knowing in an orphanage, because both of my parents had been in orphanages. I knew that however bad it was in my house, it could be worse, you know?

I really felt that she chose my step-dad over me. Then, when I was about eleven, I went through some papers and found a diary in which my Mum talked about the fact that she'd thought about giving me up for adoption. So I knew that she had already thought about giving me up [sighs]. There was really nowhere that I felt I was safe and where I was loved just for me. Now I have my own my family. This is my chance to make a safe space not just for my daughter, but for me and her father, and to create memories that are happy and healthy ... not sort of tainted.

For a long time I thought that I was intrinsically flawed

It wasn't until I became pregnant that I stopped talking to my abuser. For years I convinced myself that I had dealt with it ... that it didn't really matter ... that we were all

one big, happy family. I mean, career wise, I have been incredibly successful – I have given a paper to the UN and have done a lot of things that on the outside make me look like the abuse didn't affect me, you know? I think that I had even convinced myself it didn't really affect me. My abuser... well, there were all of these other positive things about him that outweighed the abuse. It wasn't until I was pregnant that I realized that I don't want that piece of shit near my kid! And then I thought,' If I don't want him near my kid, why do I want him around me?'

Now that I'm a mother, I'm a lot stronger. I am able to see rational, normal boundaries for my daughter and because of that, it's a lot easier to identify rational, sane, healthy boundaries for me. I am her mother, her protector. For a long time I thought that I was intrinsically flawed, that I came into this world somehow broken or damaged or something, and that was what drew the abuse to me. I have been sexually abused by a few people in my lifetime and irrespective of my outward appearances, of what I said or how hard I worked, there was something about me dirty and broken that I needed to hide. But when I had Emma, I realized that we all come into this world perfect, and that the flaw wasn't in me, it is in my abusers. It has been really difficult giving up this long-held belief that there was something wrong with me. I still ... I mean there's still pieces of it that I haven't gotten rid of ... but having Emma has allowed me to see myself differently.

For the first few weeks, I was really anxious about, the mechanics of having a baby. For instance, I didn't want to touch her genitalia because I wasn't sure if it was sexual abuse. It was really hard for me to learn that washing her and changing her were okay; not just for me to do it but for her father. Even now, if he's feeding her and she starts to cry a little bit, I have to go up and make sure that he's not touching her... and I trust my baby's father with my life. Actually, he was the one who said to me, "You know, you don't have to see your abuser. You don't have to have anything to do with him. You can excise him from your life".

I loved having a belly...

Being pregnant was the most thrilling experience of my life! I could eat from sun-up to sun-down and never get full and never gain weight! I gained thirty-five pounds, even though I bet I was putting away 4500 calories a day. It was amazing... it was

amazing! The heartburn wasn't great though. Uhm, it's funny, because the longer I talk about this, the more I remember things that I hadn't remembered before ... or maybe I am seeing them in a different way.

One of the greatest parts about, uhm, being pregnant, was my belly. I loved having a belly... we are going to try again in January and I'm looking forward to having my tummy! I loved having my tummy. I loved the sense of newness and the fact that pregnancy is a miracle. It is surrounded by a sense of newness and freshness. If God could bring such a beautiful feeling and a belly and a little baby into my life, then, uhm, I must not be all bad. I loved feeling her inside of me and I loved having that sense of protection.

Being with her in some way has healed me

I really liked the idea - and I still do - that I am protecting somebody in a good way. Like ... I'm protecting this little baby from bangs, cuts, scrapes, and hunger ... things like - but I'm protecting her in a positive way. I am not protecting her in a way that's detrimental to me. I'm not lying to protect her. I'm not hiding something to protect her. I don't have to make things up, to protect her. Before, it seemed like part of protecting myself was also protecting my abuser ... so it was, there was a lot of lying and a lot of hiding, and a lot of, uhm, yuckiness about the protection. Whereas with my daughter, it's a joy; it's a joy to be able to take care of her and to watch out for her ... and it's such an incredibly honest experience.

Some of my fears for Emma are realistic and I am getting a lot better at deciding which ones are and which ones are not. I am also able to stop myself from dwelling on the unrealistic ones. I say to myself, 'Yes. That is something I could worry about, but if I worry about it I will miss watching her do this or watch her do that... I will be so busy feeling the anxiety that I won't get to feel my love or my excitement'. I am becoming a lot more aware of, uhm, what I want to think and feel and better at controlling the anxiety I have.

I am really afraid of losing her or of her getting hurt... that's huge... But she's is a huge contributor to my feeling like a normal person. My anxiety makes me slightly overprotective and a little bit weird about letting people hold her. There are still times when I to leave the house because I'm anxious, you know? But I am a lot more able now

to say "OK, that's old stuff, this has nothing to do with your daughter, this has nothing to do with right now" ... I'm getting a lot better at letting that go.

After years of lying about the abuse, it is a joy to be with someone who's so honest. I mean, when she's hungry, she cries. When she's wet, she cries. When she's tired, she cries. When she's having fun she laughs. It's amazing being around a baby because she is so honest and that sort of reintroduction of honesty on such a fundamental, visceral level is amazing.

Another thing is watching her be in touch with her body, because for a long time I haven't been in touch with my body. But watching her touch her toes or when she has a 'pooh' and her little face gets all crunchy.... It's not like, "I'm hungry, but we're out so I won't make a noise". Like when she's hungry, man she says, "I'm hungry – feed me!" Its just an amazing thing for me to watch her say, "I'm hungry", and have people will feed her or, "That hurt", and people stop what they are doing and soothe her ... seeing that in action is amazing, 'cause that wasn't my experience.

Being with her in some way has healed me. She is such a wonderful little soul, you know. When I do sort of slip back into thinking that I am broken, I look at her and I think, "There is no way that there could be something wrong with me if I can produce this child". I don't know if this makes sense, but I think it is not so much seeing myself as her mother, it is also a bigger knowing that she loves me – that I am lovable and that she is my gift ... that the powers that be contrived to let me have this wonderful gift. I just have this overwhelming sense of love that I have had that now for the last year and a half - ever since I found out, I was pregnant.

I remember the first time she moved in me; I was standing looking out the window and I had a sense of ... being carried away... It was like I was being washed clean. When I look at my daughter and how truly phenomenal she is, I feel so blessed that someone this wonderful would choose our family to come into.

Even when I'm not being a particularly good mother to her - because there are times when the phone is ringing, she's crying, and something on the stove is boiling over – when I am not a particularly good mother. Even during those times, my love for her is there. I feel a lot safer loving - not just my daughter but also my baby's father and my Mum. I feel a lot safer with love in general, I think.

Sharon: I Have More Love

It was a whole new beginning

I knew from the time that I was sixteen years old that I was going to be a mother, so I was looking forward to it. My friends from school thought that I would be the first one to get married and have children, because I started planning for it when I turned twenty. I thought, "If this relationship works out, we will have a baby when I am done school", but that relationship didn't work out. Five years later, I met my baby's dad and we knew instantly that we loved each other and that we wanted to be with each other. We talked about what we wanted out of life and decided that we both wanted to be parents. I took into account his family and how his parents are ... how his family lived ... I thought, "You are going to be a good dad". When I decided to have a baby with him, it was me wanting to share my love with him. It was my way of saying, "I love you and I know that you are a good person". It was a whole new beginning.

I was working at a gas station at the time and one day the vapours really got to me. I had read somewhere that a woman's sense of smell may be heightened in pregnancy and I thought, "Maybe I am pregnant". My boyfriend and I waited until the weekend to pick up a pregnancy test and sure enough, I was pregnant. Later I went to my doctor to confirm it, but when I did the home pregnancy test, I knew that I was pregnant. It was like, "Okay. This is going to happen now. I'm growing a baby!" We were all excited and wondered who we would tell first and how long we were going to wait to tell them. Everybody was happy for us. My parents were a little concerned about our financial situation because my baby's dad and I had not been together for a long time ... they were concerned about our stability and our financial situation. But, uhm, they are confident that I am a good mother and that I will do a good job.

I wasn't really counting on becoming a mom

At the same time, I wasn't really counting on becoming a mom because I know that a lot of people have miscarriages ... and because I was under some stress ... I thought, "Well you never know... it might stay and it might go ... so I'm not going to set myself up for something that might not happen". Even though I felt really good ... energetic ... I also felt a little bit, uhm, worried. When the test was positive, I remember

thinking, "This is for real now. It's not just something that I want ... it is actually happening".

During the first three months of my pregnancy, I kept reminding myself, "It's just a parasite... a parasite taking over my body. It might stay and it might go. I'll do the best to make it stay, but in the long run, it's not really up to me... I'll do the best I can, but it's not really under my control". When I started feeling sick, well that was the parasite. I knew my body was being taken over, that this thing was going to eventually take over everything ... my hormones, my weight, my appetite, and my life.

It all seemed more real when I had my first ultrasound. I was thirteen weeks pregnant and that's when I started to feel ... scared ... because here's this little baby growing. I remember watching the ultrasound machine and seeing her arm wave ... it was like she was saying, "Hi". At that moment, I knew that this was a real baby; this was my baby. It was amazing. I am crying now just thinking about it.

I have more love

Yeah. I have been so emotional ever since I got pregnant ... and it just doesn't stop. A touching moment on a commercial can make me tear up ... or Extreme Home Makeover[25], things like that. Even happy things make me cry and they never did before. I think it's because I have more love. I don't really think that I am a different person; certain qualities have just become stronger, I guess. Before I got pregnant, I just did whatever I want whenever I want, however I wanted, but when I got pregnant, I couldn't do that anymore. There is no way that I could, because at that moment of conception, that's when I became a mother.

I want a safe environment

I have worked with lots of kids and I have nieces ... I have even had kids call me 'mom' by accident or to tease me, but I didn't really start feeling like a mom until I was about five or six months pregnant. My boyfriend and I were in a new relationship and we, uh, had a lot of work, you know ... certain things ... our lifestyles ... He and I were having difficulties with him wanting to do his thing and me saying, "It's not just about you any more; it's about us!" He said, "I don't drink much", but then it just got to be too much. I ended up leaving him because there are certain things that I could tolerate but

[25] A reality television program

there was no way my baby was going to be subjected to. I think that is when it became clear to me that I am not just looking after myself any more.

I wanted stability. I want a safe environment. Not just a safe home, but a safe community ... a safe environment... a safe, happy, healthy environment and not just but for him and me, but for our families as well. I did not want any alcohol or drugs. I did not want any yelling or swearing. I did not want any violence. I have seen families where there are problems ... addictions issues ... financial problems ... aggression and I don't want my baby to go through any of it. I don't even want her to see any of that, or to hear about it, or to know about it until she's older. I am very protective of her.

At the time, we were living in a neighbourhood that was not very nice and I knew that I was not going to stay there and have my baby see homeless people ... drunks ... people on drugs ... on the sidewalk. I decided that I would rather raise her on my own than have her be around that. I told him that if he chooses to drink, it would be away from us, because I don't want him near her when he does. He quit drinking a year ago, but we didn't get back together until after she was born.

I was excited to have a great big belly

I was sick from the time I was two-and-a-half months pregnant until I was nine months pregnant ... every day. The first thing in the morning I would get out of bed and head straight to the bathroom. It was unpleasant while it was happening, but five minutes later I felt okay. I was sick from the time I was two-and-a-half months pregnant until I was nine months pregnant ... every day. When I was seven or eight months pregnant it was heartburn... that sucked ... I used to eating a lot of celery, which helped. I would take celery to work with me and leave it in the fridge. Aside from those things I was really excited about it all. I had all the books and I was learning each week ... this is how big baby is and the baby now has this now ...

I saw my doctor and the public health nurse regularly. I had a friend whose baby died inside her and they didn't know about it right away. So when she told me that I was just shocked, and I thought, "I need to make sure that I go to my doctor's appointments so if anything's gone wrong, we will know about it". Seeing them made me feel more secure knowing that I was doing the right thing... my lifestyle and working while being pregnant. I also connected with the Health for Two Program and that helped out a lot. I

was thankful, not only for the information, but for the nurse to be able to come over and sit and have coffee and talk about what was going on with me. I didn't have any money, so I got some clothes, bus tickets, and milk coupons from her until I was making money myself... it was good.

I was excited to have a great big belly and I couldn't wait until I was eight months pregnant. When I got there, I wondered how much bigger I could get. I had a hard time getting out of bed or getting up from the couch, it was like, "Oh, my God, it's just getting bigger and bigger and bigger!" I would have to convince myself that it was okay to be so big, that it didn't matter how big I got because it was for the baby. I was not going to be like this forever, so it was okay. I ate well... lots of fruits and vegetables... all of my meals, and my snacks. I have never eaten so healthily in my life. I put on a good amount of weight ... less than thirty pounds and I didn't put on the last ten of those until the last month. I actually wanted to get a picture taken, but I didn't. I remember looking in the mirror at my stomach sticking out a good foot and a half. Yeah. It was fine. I was fine. I was OK with it.

It's not even a duty, it's an obligation

After I found out that I was pregnant, I quit my job at the gas station and found another as a dental lab assistant. I was on my feet all day, but I thought it was okay ... you are supposed to walk lots and lots of exercise. There was no heavy lifting involved and no chemicals - I checked the WHMIS[26] manual and everything was okay. It was great because I had something to do and, uhm, felt productive ... more in control. I never wanted to count on someone for my welfare; I always wanted to be contributing and to make sure ... I know that my life is my responsibility and nobody else's. When I was pregnant, I knew that I had to work to save up, get bills paid ... and get ready for baby. That's the way I was raised. It's my responsibility as a parent ... it's more than a duty, it's an obligation. I knew what was involved ... I have seen my friends and family members go through it, so I knew that it would be a lot of work ... I knew what I was getting into before I got pregnant.

The people that I worked with... the environment, it was good. I worked with a bunch of young women about my age and some older men. I knew that I was pregnant

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[26] Workplace Hazardous Materials Information System

when I applied for the job, but I didn't tell anybody because I needed the job. The first day we were all sitting outside smoking and talking about who is a mother and who wants to be one ... most of us wanted to be mothers and that made me feel more comfortable. I'm not even sure how the topic came up again, but about a month later I told everybody I was pregnant ... they were all excited.

I was exhausted and drugged up

My water broke on a Friday evening. I was lying on my bed, trying to have a nap before supper when I felt a pain; I turned over and my water broke. I was alone at the time, so I got up and phoned my brother and my sister-in-law, my mom, and a friend who was going to be with me. They picked me up and brought me to the hospital, leaking all the way; I could not believe how much water was coming out. It just wouldn't stop.

I was feeling a little bit of pain, but it felt like normal pain from the heavy load; I wasn't having any contractions. At nine thirty they put some gel in that was supposed to open up my cervix, but it didn't. Saturday night at ten o'clock, I hadn't dilated at all; my cervix was still really thick so they put me on 'the drip' and my contractions started almost instantly. By about one o'clock in the morning, they were one or two minutes apart. The contractions were just brutal! I tried the birthing ball and the shower, but nothing seemed to work. It just hurt and the cords and IVs were all in the way. I wasn't comfortable in the assessment room; it was really cold and the bed was hard. I should have brought more pillows. I was hungry but I couldn't eat much ... everything was just gross. I remember being really hungry, tired, and thinking, 'My baby is going to be here pretty soon... pretty soon ...pretty soon'.

A doctor asked me if I wanted anything for pain and I asked him what he had. He said, "I have morphine, gas, and an epidural". So I asked him how my baby would be affected if I took morphine and he said 'no worries', because it was a small amount and would be out of both of our systems before baby's born – so they put that in my IV.

At about ten o'clock the next morning, I was still only three or four centimetres dilated and I was just exhausted. The nurse said, "Well, you are not dilating here, so what do you want an epidural or a C-section?" I couldn't think. I just started crying. They gave me an epidural, but I had a reaction to it so they gave me Benadryl. The Benadryl didn't work either, so they had to give me something else. By then, I was zonked

right out. I was exhausted and drugged up. At noon on Sunday, the nurse sent everybody home. Within an hour I was fully dilated and the nurse said, "Wake up and get ready to have your baby". Everybody was back within fifteen minutes. They just had time to take their jackets off, wash their hands, and grab a leg. After forty-five minutes of pushing the baby was born at about six minutes to four - almost forty-eight hours after my labour started.

My body did not want to let her go because I was afraid of being a mom

I think I was too tense and stressed throughout the majority of my pregnancy. I was afraid of something being wrong with my baby. I was afraid of not being able to provide for my baby. I was afraid about her dad and me – I had a lot of fear. Yeah. The way I look at it is that she wanted to be born and I did not want to let her go yet. I don't know... I liked being pregnant, so maybe that's what it was about ... not wanting to become mom just yet ... wanting to be pregnant a little longer. My body did not want to let her go because I was afraid of being a mom.

After she came out, I was speechless. I wanted to know if she was okay. I was still afraid, because I couldn't see her. The doctor delivered her, passed her to the nurse and the nurse cleaned her up and weighed her. I don't even know who held her first, but it wasn't me. I just remember crying, asking if she was okay. I did get to hold her for a while, but then they had to take her and check her over. They were concerned about the moulding on her head; I wondered what kind of 'mold' was on her head! But she was perfect.

My past is what helps me get through today

I was glad to have a girl. A boy would have been nice too, but I choose a girl's name six or seven years ago ... for a boy, I wasn't really decided. When my boyfriend and I were together and I thought that if it was a girl, she would have his last name and if it was a boy he would have my last name, because we are not married. But she was a girl and he was not around ... he was not involved ... and it was a little sad. I was disappointed that he was not there. It, it really kicked in when I was in labour. People kept asking me, 'Where is your husband?', 'Where is your boyfriend?' He really missed out.

It was tough, but I knew that, uhm, I knew that it was okay. I was a little sad, but I would only allow myself to think about it for a split second. "Okay. He's not here, but don't think about it. So what? Look at who is here. Anyway, it is not about him; it's about me and it's about my baby". So I just breathed and tried to accept the pain and to remember that it was there, but it would go away soon.

A few years before I got pregnant I was really ill with depression. I knew that I had to go to my doctor's appointments and take my medication. It wasn't just affecting me; it affected my family as well. But I knew that I was the only person who could get myself better, by following my doctor's advice, by taking my medication, by going to my appointments ... that was something that I needed to do for myself ... not just for myself, but for my family too, because I didn't like to see them in pain.

I wonder whether working at the jobs that I have had - being exposed to the things that I was exposed to - enhanced my life or pulled me down and caused me to get sick? I don't know. I do know that certain people, certain relationships, certain situations - both good and bad - have made an impact on my life. My past is what helps me get through today. Everything that I have experienced - everything that I have been, uhm, subjected to – has helped me in one way or another. I got through it and I learned from it. So I try to look at, certain situations and things that happened and ask my self what did I learn from? How did it change me? How did I get through that?

I worked with a man who had AIDS who taught me a lot about looking ahead. Even when he was in a lot of pain and had a hard time just staying alive, he still managed to get up every day and go for a walk no matter what. Even if it took him half an hour to get off the couch, he did it because he thought that if he missed one day because he was his couch feeling sorry for himself, he might not be able to get back up again. I have had a lot of obstacles and challenges in my life. I have been to hell and back... and have lived through things that maybe some people could not. I was lucky enough to get through those difficulties with the help of my family, my friends, and my own personal strength. Conversations like that one really help me to appreciate life and to know that, no matter what, it's up to you. Nobody else can do it for you.

I can't even remember thinking about myself

She was colicky for the first three months, which was very difficult. I can't even remember thinking about myself. She cried all of the time ... all of the time ... it was tough, but I wasn't resentful. All I thought about was trying to keep her content and happy and, you know, cared for. I didn't have time to think about anything else. One day, when she had been crying for six hour straight, I remember saying to myself, 'It's not about you ... it's not about you, you know...

I was in a daze ... only getting two or three hours of sleep at a time. I would start at six o'clock in the morning, after her feeding, to getting ready for a lunchtime appointment! It was such a job to get everything ready and to make sure that she was clean and fed and ready to go. Now it's no problem. If we need to go somewhere... depending on how long we are going for ... if it's only for an hour, I just grab her, put her in her car seat and off we go.

It was tough, uhm, and my confidence didn't start kicking in until she was about three, three-and-a-half months, or four months old. I went to visit my family up north; it is like, a six-hour drive. I thought to myself, "Okay. I can do this... This is my baby and I am on my own here. I am doing a good job and I don't care if it takes ten hours to get there, my first priority is making sure that she is cared for". Yeah. It was hard. At first, I didn't want to take her anywhere, but my family kept bothering me to come and visit.

I am the kind of person who likes to be in control

I am the kind of person who likes to be in control and to have everything set, although I am starting to relax. I don't have as much control as I thought I did, but that's okay because, with a baby, you have to go with how they are doing. You can't really say, "I want you to be happy all day and not cry because I have a headache". Yeah. I am learning to ... I don't know... learning to let things go that aren't important.

I have loved lots of children and I have worked with hundreds of children, but to have your own baby calling 'Mom', even if you are tired and trying to sleep, when you hear 'Mom. Mom. Mom', you just forget about everything and, it's like, "My baby is awake. My baby wants me' and you know ... that's what I'm here to do".

We are planning on having another one sometime in the next few years... just the other day; I was remembering how nice it was to have my baby kicking inside me. I remember that feeling; it was a wonderful feeling ... her moving around inside of me... I

liked being pregnant and I don't know if I will hold the baby back from being born or not, but I am looking forward to another baby.

CHAPTER 7

LIVING IN THE WAKE OF CHILDHOOD SEXUAL ABUSE

> It is a disaster played in slow motion. It is a nightmare of exposure, fear, confusion, helplessness, and paralysis. The scream won't come out and the flight reflexes are petrified. The nightmare is made all the more Kafkaesque by the legions of spectators who serenely pass by as if nothing is happening. (Roland Summit, 1986, p. ix)

An understanding of the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse begs context. It asks about their lives before pregnancy, it asks '*What is it like living in the wake of childhood sexual abuse?*' The word *wake* seems more apt than *effects*, *outcomes*, or *consequences*, all of which connote linearity, causation, and some measure of certainty or determinism. Because the word *wake* is more ambiguous, it leaves open the possibility of capturing the depth and layers of complexity in a girl's life after she is sexually abused. According to Harper (2001), one definition of the word *wake* comes from the Proto-Germanic word *wakwo* meaning, "track left by a moving ship"; by 1806, the phrase *in the wake of*, meant "following close behind". In this sense, a wake conjures the image of a vessel slicing through water, its powerful propellers churning up waves and sending them to the surface where they create a disturbance long after the vessel has disappeared. In another sense however, *a wake* (from the "Old High German *wahta* and the Middle Dutch *watcten*, for watch or guard) is the practice of keeping vigil over a dead body through the night.

In his poem *annie died the other day*, the poet e. e. cummings (Estlin, 1991) likens childhood sexual abuse to death.

annie died the other day

never was there such a lay-
whom, among her dollies, dad
first ("don't tell your mother")had;
making annie slightly mad
but very wonderful in bed
-saints and satyrs, go your way

Although annie may have physically died as a result of the abuse, cummings might also be suggesting that the experience of father-daughter incest altered her irrevocably. Perhaps when the father appropriated annie's body solely for his own purposes, he ended her life of childhood innocence. Stripped of that innocence, she was left to confront some of life's big issues like sex and sexuality; good and evil; transgression, retribution, and redemption; and order and randomness in human existence - issues that most adults have difficulty working out. Perhaps it is the imposed secrecy and her attempts to make sense of what was happening to her in isolation that left annie 'slightly mad'.

Individuals who experience traumatic events often describe themselves as being different people than they were before the event. In his work with Vietnam War veterans, Jonathan Shay (1994) often hears, '*I died in Vietnam*'. Migael Scherer (1992) who was brutally sexually assaulted reflects, "I will always miss myself as I was" (p. 179). The poet and writer Charlotte Delbo (1995), quotes a fellow Holocaust survivor who said, "I died in Auschwitz, but no one knows it" (p. 267). How can an individual 'miss' themselves or 'die' and yet obviously live on? What, in the nature of a human experience, engenders such feelings?

Living With Profound Disruption and Loss

The women who participated in this inquiry all talked about lives marked by profound disruption and loss that, in some instances, is akin to death. As Kate says,

> *I didn't really have like a kid's life ... I think that I have been off balance for a long time ... it messes with you ... it messes with you in every way...*

Shirley believes that the horrors she lived "*interrupted*" her life when she was 11 years old. In tersely written and evocative vignettes, Elly's (1989) book, *Don't: A Woman's Word,* reveals what her childhood of physical, sexual, and emotional abuse was like.

> *I know death too. Death looks like the man my mother married. His pants down. Kids don't remember. I was a four-year-old adult. I remember. I was never a kid. I don't remember being a kid. I remember nothing useful. I remember yearning for innocence. Yearning for not knowing. Four, Nine. Eleven. Twelve. Thirteen. Fourteen. Fifteen. Fifteen began the time of yearning for memory. A different memory. I don't want to remember this.*

> *This never happened. The world is dark. There is no memory. Only his hands around my throat. Blocking. Memory gone. Speech gone. Feeling gone. No I. Nothing left. (p. 8)*

From the clinical literature, there is a clear sense that what follows in the wake of sexual abuse is influenced by a number of complex and dynamic factors related to the girl herself and the nature of the abuse (Fergusson & Mullen, 1999; Molnar, Buka, & Kessler, 2001; Putnam, 2003). Individual factors are things such as a girl's genetic make-up; her physiology (particularly her stress response systems); cognitive, emotional, and personality characteristics; the meaning she makes of what is happening to her; and the presence and the quality of social support at the time of the abuse and throughout her life. Her family situation is particularly important, as a child's risk of all types of abuse increases when family disturbances or problems such as parental conflict; family violence; separation, divorce, and the presence of stepparents; substance abuse; and chronic illness (including psychiatric illness) exist. When considering the nature of the abuse things like the girl's age, frequency and duration of the abuse, number of perpetrators, her relationship to her abuser(s), the use of violence or threats of harm, and whether or not penetration occurs are all important.

In his recent review, Putnam (2003) points out that because of its complexity, the long-term implications of childhood sexual abuse cannot be understood in terms of simple cause-and-effect relationships. He believes that this is due to

> … [t]he heterogeneity of [childhood sexual abuse] experiences, the complexity of the confounds among abuse severity variables, and a host of moderating and mediating constitutional and environmental variables together with important individual differences in coping strategies that may come into play at different points in development. (p. 273)

That said, living in the wake of childhood sexual abuse is often characterized by a familiar pattern of recurring themes including problems with mood and affect, cognitions, impulse control, somatization, relationships, and disruptions in meaning systems (Browne & Finkelhor, 1985; Draucker, 1993; Kendall-Tackett, Williams, & Finkelhor, 1993; Simkin & Klaus, 2004).

We see some of these things too, in the women's personal narratives.

I was probably about three or four when I started being abused by my uncle...it messes with you ... it messes with you in every way. It had a lot to do with why I turned to drugs. When I started getting into my teens – I was back on the reserve then – that's when I started becoming promiscuous, drinking a lot, and smoking pot... I've always excelled at school, but I started hanging out and not going home... (Kate)

~

... being a child trying to raise kids was so stressful and so terrifying, because you're trying to protect them all the time from, you know, rape and from, physical abuse and starvation ... things like that. It was so, so much work and so horribly scary. I was afraid for them all the time... (Shirley)

David Finkelhor and Angela Browne (1985) ascribe this constellation of difficulties to four interacting *traumagenic* dynamics or forces that often arise as a result of childhood sexual abuse. The first of these dynamics is a sense of *powerlessness*, which comes about when a girl's "will, desires, and a sense of efficacy are continually contravened" (p.532).

... I guess I was convenient. (Kate)

~

Sometimes one is passive because that feels safest. (Elly)

~

... I had a lot of guilt. I thought, 'Maybe it is my fault', 'If I hadn't' done this, then [the abuse] wouldn't have happened'... (Chloe)

Evidence of this is manifest in fear, anxiety, anger, sleep-disruption, hypervigilence, aggression, and depressed mood.

It seems like the only feelings that I've ever felt are anger and regret ... I have been happy once in awhile, but mostly I am angry. (Kate)

~

I have – I don't know if they're hallucinations or what – but I would have these things ... like at top of the stairs, I would have to stop and take a few breaths before I walk down because I've always had these visions of myself

mangled at the bottom of stairs... I had one therapist tell me that I was a bully... (Jane)

~

Sorrow: for a long time I thought that sorrow was all I had. I thought that I would spend my whole life mourning what had been stolen from me: a peaceful and nurturing childhood; a sense of personal integrity; a healthy and positive identity; and self worth. (Elly, 1996, p. 15)

The second dynamic, *betrayal*, erodes a girl's trust in others and in the world as a safe place, and may lead to social withdrawal, problems with dependence, and relationship difficulties.

The first thing I learned in a long list of strategies to survive my childhood, was not to trust anybody. (Elly, 1996, p. 17)

~

When it started, I didn't know what to do. I was scared and I didn't know who to turn to; I didn't know who to talk to. I tried going to my great grandma's, but then another uncle moved in there and he started abusing me too - like in the house, with my other family around. That really scared me because I thought, 'Somebody is supposed to be there to protect me'. I wasn't feeling safe and I didn't know what to say... [My mom] had developed a gambling problem and she was hardly home. (Kate)

~

There is no aggression in my mother whatsoever, just plain negligent beyond anything that anyone could imagine. So negligent that she could know that her children were being tortured and abused and she would still pass the child back to their father, right? So here, you have these two extremes, this extremely passive mother who is like an eight-year-old child ... It makes sense that my father would marry a child because he's ... intensely pedophiliac... When I was a child, there weren't any adults who were there for me. There really were no other adults who were safe. I mean none... (Shirley)

~

... just like anything else, I've had to be very independent and just internalize it and try and work it out myself. That is what I did when I was abused for years. (Chloe)

Finkelhor and Browne's third dynamic is *stigmatization*; "the negative connotations – e.g., badness, shame, and guilt – that are communicated to the child around [sexual abuse] experiences and that then become incorporated into the child's self-image"(p. 532). Stigmatization may contribute to low self-esteem, self-hate, suicidal thoughts and behaviours, delinquency, and substance use.

I could have lost my life a couple times. I've been beaten up. I've been ditched on the side of the road, you know, a country road. I put myself in a lot of danger just too ... just to have the numbness of not feeling those feelings of my childhood abuse. That's probably one reason I moved away from my family ... they were just a constant reminder. (Kate)

~

... [one therapist told me] that, uhm, I didn't have any problems except for the fact that I drank too much. I said to him, 'Well, you would drink as much as I drank if you'd had the childhood that I had!'... For a long time I thought that I was intrinsically flawed, that I came into this world somehow broken or damaged or something, and that was what drew the abuse to me. (Jane)

~

I think I danced with depression off and on for my entire life... (Shirley)

~

I did think of suicide, but most of the time I knew that what I really wanted was an end to the pain, not to my life. (Elly, 1996, p. 17)

The fourth dynamic in this model is *traumatic sexualization*, "the process in which a child's sexuality (including both feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion" (p. 531). This dynamic influences a variety of difficulties with sexual identity and sexual expression.

... that's when I started becoming promiscuous... I got pregnant at fifteen and I didn't know what to do... I felt alone because my baby's dad wasn't

there, he was in jail. I couldn't really see myself being with him for the rest of my life ... he was just there for the moment... I started experimenting with hard drugs but didn't really get into them until I was 18 or 19. By then, I was by myself and homeless, living here and there, smoking a lot of drugs, and having numerous partners... (Kate)

~

I grew up thinking that weak women were subject to physical processes such as menstruation and pregnancy, which they could not control and were required to deny. Males, who I thought were strong and definitely got to do what they wanted in the world, lived their lives entirely beyond physical processes. (Elly, 1996, p. 21)

Early research comparing children without histories of childhood sexual abuse to those with positive histories found that the latter have consistently higher rates of behavioural, social, emotional, and psychological problems in childhood and into adulthood. This led to the speculation on the existence of an identifiable 'childhood sexual abuse syndrome' (e.g., Kiser et al, 1988), which included many of the features of PTSD[27]. This has been difficult to demonstrate because a number (approximately 20%) of individuals with histories of childhood sexual abuse apparently have no residual difficulties (Fergusson & Mullen, 1999). Current thinking is that childhood adversity disrupts a child's developing sense of self which contributes to problems with emotional regulation and interpersonal function that are the ground for other emotional and psychological problems (Briere & Runtz, 1990; Putnam, 2003). As we saw in Chapter 1, these processes are developmentally sensitive and interact with interpersonal, neuronal, and behavioural factors.

Etched by Uncertainty and Fear

Looking back on their childhoods, the women in this study remember living with fear and unpredictability. Elly (1988) writes, "*The world is dark*", while Debbie calls it '*a cruel place*', and Shirley describes her childhood as "*...so, so much work and so*

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[27] Symptoms of PTSD include such things as intense fear, helplessness or horror; persistent re-experiencing of the traumatic event; persistent physiological arousal; avoidance of anything associated with the event and a generalized numbing of responsiveness.

horribly scary. I was afraid for them [her siblings] all the time…" When Kate's uncle began abusing her in her grandparent's home, she escaped to her great-grandmother's house, only to have another uncle abuse her there - even when other people were present in the house. She said,

> *[t]hat really scared me because I thought, 'Somebody is supposed to be there to protect me'. I wasn't feeling safe and I didn't know what to say.*

When she eventually told her parents what was happening to her,

> *… they didn't acknowledge it. It's kind of like they put it on the backburner or something. That really hurt because I thought parents were supposed to protect kids.*

Now as a young adult, Kate suspects that her mother and other members of her extended family were also sexually abused and that they may not have any idea about how to protect their children.

Jane considered telling her mother that her stepfather was abusing her, but held back after she found an old diary in which her mother considered putting Jane up for adoption. Both of Jane's biological parents had lived in orphanages. She had listened to their stories and she knew that it was possible for a child to be without a home and family. Even though her home was not a safe place, in the balance, she decided it was probably better than being cut loose into the world.

> *Then, when I was about eleven, I went through some papers and found a diary in which my Mum talked about the fact that she'd thought about giving me up for adoption. So I knew that she had already thought about giving me up [sighs]. There was really nowhere that I felt I was safe and where I was loved just for me. (Jane)*

Living with fear and uncertainty about their survival and safety and having few resources to do anything about it, created situations of serious and ongoing stress for the participants (Lazarus, 2001). As I explained in Chapter 2, the perception of a threat to one's life or personal integrity activates, what Cannon (1939) called the *fight-or-flight* response, mediated by two physiological systems (Saplosky, 2004). The first of these instantaneously releases norepinephrine (noradrenaline), which acts on the adrenal gland to release adrenaline (epinephrine). The rush of adrenaline stimulates the sympathetic

nervous system, which increases heart rate, blood pressure, and respiration, and shifts blood from the body's core to its periphery. This series of events prepares us, in the short-term, to run away or fight off a threat and produces the physical sensations we associate with fear: pounding heart, gasping breath, trembling, 'goose bumps', pallor, dry mouth, distortions in time perceptions, etc. When the danger passes or we successfully evade or deflect it, our body quickly returns to its normal state.

The second stress response system - the hypothalamic-pituitary-adrenal (HPA) axis – mounts the more prolonged response required when stressors are chronic (Kindlen, 2003). Stimulation of that system causes the hypothalamus to release corticotrophin-releasing hormone (CRH), which in turn, induces the pituitary gland to secrete adrenocorticotrophic hormone (ACTH) into the blood where it travels to the adrenal gland and triggers the release of cortisol. Cortisol is a powerful steroid hormone that acts throughout the body to sustain a response to an ongoing stressor. The actions of cortisol involve metabolic changes to sustain energy, augmentation of adrenaline's effect on the cardiovascular system, perceptual changes that dull pain and alter memory processing, and immune suppression.

When stressors are extreme or chronic (e.g., being held captive, ongoing domestic violence, and repeated childhood physical and sexual abuse) the HPA axis may not return to pre-trauma levels (Yehuda, 2004). As Judith Herman (1992, p. 34) explains,

> [when] neither resistance not escape is possible, the human self-defence becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the danger is over.

These changes can permanently alter perceptions, systems of meaning, ability to regulate emotion, and the ability to relate with others; this uncertainty and fear are etched into a girl's body and psyche. A large body of evidence now exists, that links chronic HPA axis activation, childhood adversity, and a range of health problems (see Chapter 2 for a more complete discussion).

There are clear associations between childhood trauma, depression, and anxiety (Ballanger et al, 2004; Cutler & Nolen-Hoeksema, 1991; Kendler, Karkowski, & Prescott, 1999; Putnam, 2003). The finding that women with histories of childhood

adversity have a 4-fold increased risk for depression, leads some to conclude that major depression and PTSD evolve along the same etiological pathway (Breslau, Davis, Peterson, & Schultz, 2000; Stein & Kennedy, 2001).

These connections are certainly borne out by some of the women in this inquiry, who describe ongoing problems with anxiety and depression. Jane describes chronic anxiety along with disturbing 'visions',

> *... about three years ago when I was walking down the street and all of a sudden I felt someone come up and put a gun to my head. I saw my brains hit the wall and I saw myself hit the ground ... I thought, 'Right. I need therapy!'*

Elly (1996) writes,

> *[t]he anxiety level I lived with was unbearable without Valium".*

As well, Jane, Elly, and Shirley all experienced episodic bouts of depression throughout their lives, some of which were associated with fluctuations in their reproductive hormones.

Like other girls and women in similar circumstances, some of the participants attempted to avoid or reduce their distress with alcohol and drugs. Kate's told me,

> *I started smoking joints at thirteen ... [and] experimenting with hard drugs but didn't really get into them until I was 18 or 19. By then, I was by myself and homeless, living here and there, smoking a lot of drugs, and having numerous partners... just to have the numbness of not feeling those feelings of my childhood abuse.*

For almost twenty years, Elly (1996) lived in a fog induced by prescription drugs. She writes,

> *They just gave me ever-stronger prescriptions, and instructions to take the drug [Valium] more often. I was a twenty-six year old basket case, in the doctor's office every couple of weeks, and spending most of my time trying to figure out a nice, painless way to die. No one ever asked me why.* (p. 35)

Another dimension of living with chronic anxiety and fear that has come up repeatedly in this inquiry and elsewhere, is the importance of having a sense of control over one's self, one's life, and the environment.

> *I am the kind of person who likes to be in control and to have everything set... (Sharon)*

~

> *... there were times when I was really afraid to go out because inside my house I could control the environment, but outside I was really afraid of what would happen... (Jane)*

Although the notion of control often has negative connotations, it can also be seen as an individual's attempt to increase predictability and personal agency. As we will see in the following section, control or manageability is vital to an individual's well-being.

Fractured Beliefs

Childhood sexual abuse affects a girl's beliefs about her self, her relationships with other people, and her views of the world and her place in it. Earlier, I introduced Ronnie Janoff-Bulman's (1992) notion of *fundamental assumptions*. As you may recall, Janoff-Bulman believes that unless experience convinces us otherwise, we operate from the assumptions that the world is benevolent and meaningful, and that we are worthy. We establish these assumptions in early infancy, and they are foundational to our whole belief system and our confidence and trust in the world as an orderly and safe place.

Aaron Antonovsky's (1979, 1987) *Salutogenic Model of Health*, integrates ideas from cognitive psychology (like Janoff-Bulman's) with those from the stress literature. A central concept in Antonovsky's model is what he terms *sense of coherence*, which has three components comprehensibility, manageability, and meaning. Comprehensibility reflects an individual's global, enduring (though dynamic) confidence that their internal and external environments are predictable. Manageability is the extent to which one believes that their available resources are sufficient to meet the demands they face. Finally, meaning is a sense that the individual's life has value and worth. According to Antonovsky, those of us who have a high sense of coherence are healthier and better able to manage the stressors of life.

The participants' narratives make it clear that sexual abuse undermines their sense of coherence. As we saw earlier, sometimes the pain and devastation are so profound that it feels like a death of sorts. For some of the women, every day can feel like a struggle to survive. As Elly (1988) recalls, she did this by locating and protecting,

> *[a] tiny light... My secret. My soul. A self"* (p. 9).

A key feature of a coherent world is that it is logical and predictable and therefore, manageable. Parents invest a great deal of energy teaching their children rules about how the world works. Some of the most common of these are: touching something hot causes pain; if handled roughly, a delicate ornament will break; eating good foods makes you strong and healthy; family is safe, strangers are dangerous; be 'good' or else 'bad' things will happen to you. Once we learn these rules, we expect the cause and effect relationship inherent in them, to remain invariant. This reiterates Ronnie Janoff-Bulman's (1992) and Antonovsky's (1979, 1987) belief in the importance of perceiving the world as meaningful.

Kate refers to her understanding of 'how things are supposed to be', when she says,

> *I thought parents were supposed to protect kids*".

Chloe also alludes to this, when she cannot believe that

> *[a]fter the trial was over, everybody seemed to want life to go on as if nothing had changed. It was like, 'Let's just forget about it and move on'... even though I can't forget about it.*

She found it particularly upsetting to see her uncle seemingly go on with his life "... *as if nothing is wrong...*"

Chloe's uncle's abuse of her tore clean through the very fabric of how she understood life is to be; the impact was so great that she remains incredulous that others can carry on as if nothing is different. Even laying criminal charges, having the Court declare her uncle guilty, and seeing him serve a jail sentence does not provide sufficient closure. Perhaps there is something about her grandmother's refusal to acknowledge what happened to her, or her mother's guilt and anger that continually pull Chloe back into her own feelings of anger and powerlessness.

When something bad does happen, we actively resist believing that it is a random occurrence. In fact, research supports the conclusion that most of us have a tendency to see ourselves as uniquely invulnerable; we underestimate the risk of negative events and overestimate the likelihood of positive events occurring in our life (e.g., Perloff, 1983; Taylor, 1990). Our first response to an adverse event is typically to ask, 'Why?' Embedded in this question is the assumption that the world is meaningful and that every occurrence has a reasonable explanation.

In his *just world* theory, Melvin Lerner (1980) posits that we prefer to believe that 'individuals deserve what they get and get what they deserve'. To think otherwise, raises the possibility of an arbitrary world. In such a world, individuals – even those who are 'good' and live by all of the rules - have no control over what happens. It is a scenario in which the world is not predictable, just, or manageable; it leaves us at the complete mercy of the cosmos – a thought that causes profound anxiety in many adults and is incomprehensible to children.

When he was casting about for a research topic for his doctoral program, Martin Seligman (1975) noticed something unusual in the animal lab. Instead of jumping from one section of an apparatus to another to avoid an electrical current in the wire floor, dogs were laying down upon it. Seligman could not understand what would induce an animal to submit so passively to an electrical shock, until he realised that a malfunction caused current to flow through the floors of both sections of the apparatus. No matter what the dogs did, they could not avoid the shock. After several attempts to escape, they would stop trying and simply lay down. From this serendipitous observation, Seligman developed his theory of *learned helplessness*, which is widely acknowledged to be an animal model of depression. The theory of learned helplessness predicts that if an individual believes that they have no control over what happens to them, they will become depressed, which is characterized by feelings of sadness or melancholy, loss of interest in life, and changes in appetite, sleep patterns, sexual desire, and levels of energy.

The Undoing of a Self

Applying Janoff-Bulman's (1992) ideas about *fundamental assumptions* (benevolence, meaningfulness, and worthiness), Antonovsky's (1979, 1987) *sense of coherence* (comprehensibility, manageability, and meaning) together with Seligman's

(1975) *learned helplessness* to the experience of childhood sexual abuse, may provide further insight into what it is like to live in its wake.

Through the process of socialization, children learn the 'rules' of the larger social group that I referred to earlier. Some of these rules are explicit and others are implicit. The rules convey information about all aspects of how to function within the group (e.g., shared meanings, norms, morals, ethics, taboos, religion, spirituality, etc.). Through them, children begin to make sense of the world – how it is supposed to function, who they are in relation to other people, what is valued, how to behave – everything. Although in reality, the sanctions for breaking these rules vary from minor disapproval to ostracism, from a child's limited perspective these distinctions may not mean much. Until they are capable of abstract thought, little ones see things as 'black' or 'white', 'good' or 'bad'. When the world operates according to these rules, children (and all of us) have a sense of coherence (Antonovsky, 1979), a sense that the world is good (and if not good at least it is just), manageable, and meaningful. It also affords them a sense of mastery or agency, which is antithetical to helplessness.

Because sexual abuse breaks rules that have to do with older or bigger people looking out for younger, weaker ones; about not hurting other people; and about touching certain parts of the body, an abused girl's meaning system is threatened. Frighten and confused, she looks to trusted others – usually parents and other family members – for help to understand and rectify the situation. When no one acknowledges that there is a problem or they ignore her request for help, she is thrown into a state of crisis. She is in danger and no one is rushing forward to protect her. To the contrary, she is often told that she is responsible for what is happening to her or that she is lying about it. The explanation that makes the most sense to her usually goes something like – 'No one wants to talk about this, it must be bad. Only bad people do bad things. *I* must be bad or my family would help me. If I say anything about this, everyone will realize how bad I am; I'll cause trouble, people will be angry and hate me. I am nothing'.

This is exactly what happened to Chloe when she told her grandmother about what her uncle was doing to her,

> *... she kicked me out of the house and said that I shouldn't make up such stories and that things like that happen, you just live with it.*

When Jane told her school nurse and later a school counsellor, she was accused of lying because

> *... things like that don't happen to girls like me ...* [and later to] *... ask God to forgive me for my sins.*

Kate was confused that adults (who usually know so much about everything else that goes on) did not seem to notice that her uncle was abusing her. When we spoke, Shirley told me,

> *When I was a child, there weren't any adults who were there for me. There really were no other adults who were safe. I mean none...*

This was apparent in her National Film Board documentary, *To a Safer Place* (1987), in which she returned to her home community and asked her family's neighbours what they remembered about her and her siblings. One couple remembered them as dirty and as being on their own most of the time. In the next breath, they talked about the sanctity of the family and society's injunction not to interfere in a family's affairs. Elly (1988) writes,

> *There is no help. My grandmother is a continent, an ocean, away. I try to tell my teacher at school. She says: You are subject to your father in all things. He is your lord as jesus is your lord. He would do no harm, no wrong. He is right in all things. If you are punished or hurt it is for your own good. If he is too rough it is because he loves you. Pray to jesus for comfort.* (p. 15)

All of this tends to leave a girl struggling to hold on to a sense of personal value and worth. We find evidence of this in Jane's comment, "[f]*or a long time I thought that I was intrinsically flawed*" and Chloe's belief, "*I don't deserve to be happy*".

Rising From the Ashes: Resilience and Healing

From Damasio's (1999) work - and from our own experience - we know that, although our consciousness (what he calls the *core-self*) is seamless, it is constantly being modified through our interactions with the world. When something bad, like sexual abuse, happens it changes how a girl views and relates to the world. By bringing her face-to-face with the human capacity for evil, it fractures any assumption she has that the world is a good and it sensitizes her to the dangers that exist all around her. While this

does afford her a more realistic view of how the world actually is, that information comes at a time in her life when she lacks the maturity and the resources to understand and deal with it. As we saw earlier, helplessness in the face of danger is at the heart of psychological trauma and can alter an individual's biology.

Before moving on, I want to return to Damasio's (1999) contention that the core-self is continuously shaped by experience. Experience teaches us about the world and about our self in relation to that world. When we live through a traumatic experience, we learn about danger, but we also learn about our own strength, capacity for healing, resilience, and agency. Think back to Shirley's statement:

> *... I never felt incompetent ... I felt we could do anything and we did do anything. We did do everything that we needed to do. We raised ourselves. The fact that I had children to raise ... I mean that's the best thing that ever happened to me. Not only did I have to do it all myself, but I had other people depending on me... That was amazing because when you have people depending on you there's nothing you can't do.*

Sharon echoes this when she says,

> *I do know that certain people, certain relationships, certain situations - both good and bad - have made an impact on my life. My past is what helps me get through today. Everything that I have experienced - everything that I have been, uhm, subjected to – has helped me in one way or another. I got through it and I learned from it. So I try to look at, certain situations and things that happened and ask my self what did I learn from it? How did it change me? How did I get through that?... I have had a lot of obstacles and challenges in my life. I have been to hell and back... and have lived through things that maybe some people could not. I was lucky enough to get through those difficulties with the help of my family, my friends, and my own personal strength... Nobody else can do it for you.*

As we shall see, this capacity for regeneration and growth becomes particularly prominent when a woman learns that she is pregnant.

CHAPTER 8

RESPONSE-ABILITY TO MOTHERHOOD

> Pregnancy is a time of monumental change for women – a time when the past, present and future all come together, a time of openness, a time of vulnerability. (Simkin & Klaus, 2004, p. 34)

The confirmation of pregnancy awakens women to new ways of seeing and relating to themselves and to the burden of responsibility for (an)other's well-being. Like other pregnant women, the women in this inquiry were often hungry for information about how to support the life growing inside of them. Along with their maternity care providers, they monitored their bodies for cues that all was well, that they were doing things 'right' - that they were being 'good' mothers. Pregnancy and birthing also took the women on a roller coaster ride of extreme joy, love, uncertainty, anxiety, guilt, loss, and ambivalence. No matter how much they learned through reading, television, and talking with others, many of them still felt unprepared … for labour … for the enormous and unremitting responsibility they feel for their children … for all of the unseen challenges that lie ahead.

Their life circumstances at the time they became pregnant influenced their perceptions of pregnancy and their ability to respond and care (i.e., their response-ability) for a child. The women who felt safe, stable, and supported, tended to welcomed pregnancy and birthing as positive experiences. On the other hand, pregnancy and birthing were crises and even re-traumatizing for the women who felt unsafe in the world and/or lived in unstable circumstance and lacked support. Like some of the women in the latter part of Chapter 3, the women in this study experienced stress, worry, and fear throughout their pregnancies. What was different though is that some women with histories of childhood sexual abuse seem to have a more immediate sense of the world being an unsafe place. This 'deeper bruise of knowing' (Lawrence, 1916) about dangers of life keeps them at the edge of anxiety. The women do not trust easily and are constantly vigilant for any hint of danger, particularly where their children are concerned. Some of them even worry that they have been so damaged by the abuse that their very presence may harm their children.

Safety, Stability, and Support

Although safety, stability, and support are important for all of us, they are particularly so for women with histories of childhood sexual abuse. In fact, for the women in this inquiry, the degree to which they felt safe, stable and supported was a key factor in whether they perceived their pregnancies to be positive experiences or re-victimizations. These things were also coloured some of the women's response-ability to motherhood.

A 'yes!' to being pregnant

Until she met the man who would become her husband, motherhood was 'optional' for Debbie. Through her teens, twenties, and most of her thirties, she had explored the world and other aspects of herself through travel, work, and relationships with friends. Her ambivalence toward pregnancy disappeared when she met a man she immediately respected and loved.

> *The first time that I met my husband ...I completely fell in love with him in a way that I had never done before... I said 'You know this is one of the finest men I've ever met' ... I just gave my heart to him. We got married right away and a week later, I got pregnant ... All I knew was that there was a 'yes' to get pregnant. Like I ... there was a space ... it was like, I could do this. I'd never really wanted to...thankfully I had some really good friends that - not a lot of them were parents - but they all really supported me and really loved my husband and what we were doing... (Debbie)*

For Sharon, pregnancy was a long-held dream come true. Although she began looking forward to it in her mid-teens, she waited until the conditions in her life were 'right' before deciding to get pregnant. What made things 'right', was being in a loving relationship with a man who wanted children and whose family values were similar to hers.

> *I knew from the time that I was sixteen years old that I was going to be a mother, so I was looking forward to it. My friends from school thought that I would be the first one to get married and have children, because I started planning for it when I turned twenty. I thought, "If this relationship works out, we will have a baby when I am done school", but that relationship*

didn't work out. Five years later, I met my baby's dad and we knew instantly that we loved each other and that we wanted to be with each other. We talked about what we wanted out of life and decided that we both wanted to be parents. I took into account his family and how his parents are ... how his family lived ... I thought, "You are going to be a good dad". When I decided to have a baby with him, it was me wanting to share my love with him. It was my way of saying, "I love you and I know that you are a good person". It was a whole new beginning.

Jane, like Chloe and Shirley, had been told that she had physical problems that could make becoming pregnant difficult, maybe even impossible. For that reason, she did not use birth control and had set the issue of pregnancy on the backburner, turning her energies to career and travel. Shortly before she learned that she was pregnant, she had returned to Canada to begin therapy with her mother to resolve longstanding issues between them. Things were going well and she was feeling positive about herself, the direction her life was going, and her relationship with a man she trusted. She was so surprised to discover that she was pregnant, that it took several home pregnancy tests to convince her that it was true. During our conversation she mused

I'm just thinking that maybe it is not a coincidence that I hadn't used birth control for years and didn't get pregnant until I was with someone I could trust. Maybe I was holding back. I have never thought about it quite like that before. My partner is the smallest man I've ever dated. He's six years younger than me, 3 inches shorter, and 30 pounds lighter than me, and yet he's the person who's stood up for me and protected me... and I mean, I dated a guy who was six foot nine [laughs] and 280 pounds and my partner is the first person that stood up for me.

Although things were coming at her quickly – a transatlantic move, therapy, pregnancy, and the death of her grandmother – she was *over the moon* with joy.

Emotionally, I was overwhelmed with what was going on and excited about becoming a mom. I am in my mid-thirties and we were thinking about having a baby in a couple of years and when it happened I wondered, 'Why have I waited until I was thirty-four to have a baby?' I think part of the

waiting was my subconscious knowing that there was no possible way I could raise a healthy child until I had dealt with my sexual abuse or at least had started to talk about it.

Debbie, Sharon, and Jane - the women who experienced a resounding 'yes' to being pregnant - all have three things in common. They were feeling safe in the world and in their relationships with their male partners; their life-circumstances were relatively stable; and they all had adequate social support.

From Spiegel (1944) and Kardiner's (1947) early work on the protective effects of social support against combat trauma, to the recent literature on postpartum depression (e.g., Records & Michael, 2007) it is clear that social support is a key factor to well-being. Not only did the presence of social support enhance these participants' response-ability to motherhood, it helped to mediate some of the negative effects of childhood adversity, positively influenced the women's sense of self worth, and helped them to relate to their bodies and their sexuality in new ways.

Even sex was different for me after I got pregnant. It was full of firsts - like the first time I had sex when I was pregnant and I knew I was pregnant... the first time I orgasmed when I was pregnant, the first time I had my breasts stimulated when I was pregnant, the first time I got a massage when I was pregnant – all of that... It was almost if I had my virginity back, because it was new. (Jane)

Despite experiencing some of the common physical discomforts of pregnancy, Jane and Sharon both relished their pregnant bodies.

I was really excited about it all. I had all the books and I was learning each week ... this is how big baby is and the baby now has this ... I was excited to have a great big belly and I couldn't wait until I was eight months pregnant. When I got there, I wondered how much bigger I could get. I had a hard time getting out of bed or getting up from the couch, it was like, "Oh, my God, it's just getting bigger and bigger and bigger!" I would have to convince myself that it was okay to be so big, that it didn't matter how big I got because it was for the baby. I was not going to be like this forever, so it was okay. I ate well... lots of fruits and vegetables... all

of my meals, and my snacks. I have never eaten so healthily in my life. I put on a good amount of weight ... I actually wanted to get a picture taken, but I didn't. I remember looking in the mirror at my stomach sticking out a good foot and a half. Yeah. It was fine. I was fine. I was OK with it. (Sharon)

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One of the greatest parts about, uhm, being pregnant, was my belly. I loved having a belly... we are going to try again in January and I'm looking forward to having my tummy! I loved having my tummy. I loved the sense of newness and the fact that pregnancy is a miracle. It is surrounded by a sense of newness and freshness. If God could bring such a beautiful feeling and a belly and a little baby into my life, then, uhm, I must not be all bad. I loved feeling her inside of me and I loved having that sense of protection. (Jane)

Through her pregnancies Debbie found a new understanding of and connection to her body and to her feminine sexuality.

You get to understand, 'Oh, that's what my breasts are for', 'That's why I have hips' ... it's like all of the sexual connotations of women's bodies - the curves and all of that - it's so crude in a way. Because breasts are for breastfeeding, you know? Hips are for birthing a baby!

Debbie, Sharon, and Jane's experiences are consistent with Peggy Richardson's (1990) contention that pregnant women perceive their changing bodies to be synonymous with their growing babies. In a sense, the physical changes of pregnancy do not belong to them, but are an extension of their babies. As women monitor and relate to their changing bodies, they begin to identify themselves as mothers. In caring for themselves, they are caring for their babies.

Uncertain pregnancy

When safety, stability, and support are missing in a woman's life, the news of a pregnancy is a stressor that creates uncertainty and anxiety...

... my baby's father was not sure whether he wanted to be a father at the time, so that did not help; that put a lot of stress on me. (Chloe)

I had no support from my husband, my family, my doctor – it was like living in a vacuum. I felt totally alone in my pregnancy. (Elly)

Although Chloe had looked forward to becoming a mother, her partner was not quite ready for parenthood when she became pregnant. His hesitation left Chloe feeling unsupported and alone, not unlike how she felt as a young adolescent when she was being abused by her uncle. Her happiness about being pregnant was quickly overshadowed by feelings of guilt and shame and a sense of unworthiness.

When I found out I was pregnant ... I was excited and then right away I said, 'No. I can't be. This isn't right... I felt ashamed and that it was my fault that it all happened. I felt like a little kid, like a young teenager who is pregnant and should not be... I should have been ecstatic ... I ... lots of times I wished that maybe the child would not survive. Lots of times I felt, 'Well I almost hope this child just doesn't make it', just to prove to everybody that, you know, I'm not supposed to be a mother; I'm just not worthy of this. I felt that I don't deserve to be happy ... I don't deserve to be a mom, even though I wanted to for so many years.

Like some of the women in Elaine Westerlund's (1992) study, Chloe felt exposed by her pregnancy – it was evidence to the world that she was a sexual being and that left her feeling vulnerable and ashamed.

Although her partner did come to accept Chloe's pregnancy, she did not feel completely supported by him. This caused her stress on two counts – firstly, her lack of surety about her partner's commitment to her and their baby created a sense of instability; secondly, she worried about how her own emotional turmoil might affect her unborn child.

A big stress for me was that babies feel stress from their mom, so I was trying so hard not be stressed out.

As well as feeling stressed during her pregnancy, Chloe felt emotionally flat.

Through pregnancy I ... I don't know that I would say that I was depressed, but I was not excited about it ... about being pregnant even though it was something that I wanted all my life

Even after their son was born, Chloe's partner was not as involved with their baby as she would have liked him to be.

> *At the beginning, after our son was born, I felt like a single mom because he was not involved. Talking with other moms, I find that it's almost like dads don't come into the picture until the child responds more - basically around six months when they start doing more – then almost magically they become dads. It's just, very odd.*

When they discovered that they were pregnant for their first time, Elly and Kate were very young and struggling to locate and preserve their selves in amongst chaotic relationships with their families of origin, sexual abuse issues, and drug and alcohol use. Their life circumstances sorely taxed their response-ability to motherhood.

Elly was consumed by an inner turmoil that began in her childhood that carried over into the difficulties she was having with her husband. This left her feeling very detached from her first pregnancy, which ended with a stillbirth.

> *The whole experience left me in shock for a long time. My in-laws and my husband became very concerned because they thought I wasn't grieving appropriately. Of course, I was dissociated, so it was not as if it was a real baby... my baby. It was just something that happened. It was something that just happened, but it was not connected to me. It was as if it was somebody else's baby. It was not part of me or my body or my consciousness. I felt no connection to that baby whatsoever.*

Now sixty years old, settled into a stable and satisfying life, Elly feels more connected than ever to her past self, her feelings, and to her dead son.

> *From this distance it grieves me now. I grieve for the young woman that I was, and how - you know - and how terrified and alone I was then; but at the time, I was grateful. That baby was born on February 3. I think about him every year and, on occasion, I talk to Thomas about his brother. That baby is more real now than it was at the time, but I am a lot more connected to the world than I was at that time too.*

When she became pregnant with her second son, Elly was still not ready for motherhood but she did feel an emotional attachment to her unborn baby and more confident in her own ability to birth him.

> *When I got pregnant again though, something was different. Thomas was born in August, so it would have been sometime in the winter - late February or March, something like that; I felt the presence of a real baby. I remember having these inner conversations with him like: 'Well, you know, I have nothing to give you... I'm scared to death of hurting you'. I was very anxious about what I could do to a baby because I was so mixed up and distraught on so many different levels. At some point, there was – it was almost like there was an answering consciousness – giving me a strong message that everything was going to be okay. I settled down and I started to think about whether it was a boy or a girl and started to engage with my pregnancy in a way I had not the first time.*

Although Kate spoke of wanting each of her children her life circumstances have always been precarious. Pregnant for the first time at 15, she had little support from her mother or from her children's fathers.

> *I got pregnant at fifteen and I didn't know what to do. I was kind of ashamed and I didn't know what to tell my mom. I felt alone because my baby's dad wasn't there, he was in jail. I couldn't really see myself being with him for the rest of my life ... he was just there for the moment. ... I have never really had a boyfriend until I got pregnant... but it never lasted. I have some contact with my first son's father but he's an addict ... he's into sniffing exhaust and lot of other crap – yuck! I don't know ... I picked unhealthy people to be my children's fathers and I feel bad about it because my kids don't really have fathers. My other son's dad is a crackhead in Calgary. Last time I was there, he threatened my life...*

Now at 23 years old, Kate is pregnant with her third child. Of all of the women I spoke with, her life is the most unstable and dangerous. Like her parents and some of her extended family, she wrestles with addiction to alcohol and drugs. While they afford her

some reprieve from her pain, they keep her tied to the street life, which is anything but safe.

> *My physical health has been in danger a lot of times and I could have lost my life a couple times. I've been beaten up. I've been ditched on the side of the road, you know, a country road. I put myself in a lot of danger just too ... just to have the numbness of not feeling those feelings of my childhood abuse.*

Although Kate did not plan any of her pregnancies and would likely not say that she is ready for motherhood, with each of them she has responded with efforts to create safety and stability, and to find some support for herself. As soon as she thinks she might be pregnant, she seeks health care and gets connected with local pregnancy support services. In fact, she saw the poster advertising this study on the wall in the clinic where she receives prenatal care.

> *... I'm excited to have a baby because I kind of missed out on my other sons' lives. I'm scared though, of labour and stuff, but I'm happy that I going to have another baby. I was in a treatment centre twice and I just completed one about a month and a half ago, two months ago. I'm looking forward to being clean and sober. It kind of affects me ... my health ... like my emotional health and my mental health and spiritual health...*

She is guardedly hopeful that she will be able to maintain the changes she needs to make in order to stay sober and clean.

> *I am feeling confident now, but the more times that I've tried to quit drugs the harder it is for me to quit. It seems that hard drugs are just ... we are best friends practically. They are all I have known for the past eight years although I quit for my pregnancies. I quit cold turkey and with this baby and I'm finding it really hard. I am struggling every day. I try to write things down about how I feeling and stuff but it doesn't work.*

Kate thinks she might like to have more children when she is older, if the circumstances of her life are right.

> *... I want to have more kids when I'm in my thirties or something like that. I don't want to be with a guy right now – because I need to get healthy... I*

want to find someone that's healthy, someone who just doesn't want to get laid and then leave ... I can't do that anymore. I want to find someone who is emotionally balanced ... healthy. There aren't too many men around my age ... looking for a girl with like three kids, you know? But that's okay. I am ready to just to live my life and be with my children.

Perhaps the women in the study who did not feel an immediate openness to pregnancy can best be understood, not as rejecting children or motherhood, but as having a deep uncertainty about their own adequacy and their ability to provide a safe and secure life for their children. Sometimes this manifested as physical problems, anxiety, and profound self-doubt.

During the first trimester I had high blood pressure that everyone thought was because of the salt I ate. I didn't want to tell them that it was because of stress... I also had extreme morning sickness up until five months and then had to be on short-term disability because I ended up with bronchitis three times during my pregnancy so, I was actually quite sick. (Chloe)

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In my fifth month, I was losing amniotic fluid and was on bed rest for an entire four months, which was really hard for me... It is an awful thing to consider the life and death of this child growing in your body. 'Are you gonna be able to make this happen? Is this baby going to make it? Are you gonna be able to perform the most important performance of your life to keep this child alive?' That's ... that's pretty formidable, for me personally. I didn't think my body could do that again. It was a miracle that, that James survived. I'm an excellent mother, but I am useless at carrying babies.

Alien invasion

Although their life circumstances were quite different when they became pregnant, Elly and Shirley both described their pregnancies as an *alien invasion*. Although Elly had not yet begun to come to terms with her past, it was always bubbling near the surface of her consciousness; her primary strategy to manage her chronic anxiety and depression was increasingly higher doses of Valium. In contrast, Shirley had reached

a place of equanimity in her life, pregnancy cracked open her defences, pushing her to the brink of chaos. Both of these women, feeling unsafe and out of control, experienced pregnancy as invasion that was reminiscent of their past abuse.

> *I was not ready to be a mother, but I was not given a choice in the matter. You were married, your husband decided when to start a family ... he decided that I would have children, and on we went. The whole experience left me in shock for a long time ... Of course, I was dissociated ... (Elly)*

Before Shirley became pregnant, her life had been good. She was with a man she trusted, had a well-paying job, and for the first time in her life felt free from the demands of caring for her siblings. She had no desire to be a mother and, if she had believed it was a real possibility, would have likely have taken steps to ensure to she never got pregnant.

> *I never wondered much about what it would be like to be a mother because I felt like I already had done that... I don't know a time when I didn't feel like a mother, you know? Like many children who live in dysfunctional homes, I was the child who took the role of being mom ... I felt old and like a parent before I ever became a parent. So, um, and I had no desire, of children, because I felt pretty exhausted and worn out by parenting already as a child.*

Confirmation of her pregnancy threatened Shirley's defences, allowing memories of her childhood ominously close. Her immediate response was to create the illusion that the baby she was carrying was a girl. This allowed her to stave off the horrifying thought that she might pass the genes of her father on to a boy child.

> *When I first found out I was pregnant I was shocked and then I developed this hallucination or something – they were always really good for me - to help me through trauma. I invented this 'knowing' that the baby was a little girl and that just made everything safe... I totally felt that there was something foreign, a foreign person, inside me and I did not feel a big sense of attachment at all. It was like that Sigourney Weaver film where she had that alien inside of her. It didn't feel like it was part of me. I wouldn't help it or hurt it, but I would do the best I could for it to make it through ... and I would certainly never destroy it.*

Pregnancy was extremely difficult for Shirley on a number of levels. It brought her awareness back to her body – the site of the incest and abuse; it brought her back in contact with the 11-year old girl in a bathtub full of blood; and it brought her back to the anxiety and fear of caring for children in a dangerous world. Her belief that she was carrying a girl-child was literally the life preserver that got her through pregnancy; her son would be a year old before she re-emerged from the trauma of his birth.

Awash in helplessness

Like the women whose voices we heard in Chapter 3, the participants in this inquiry spoke of experiencing anxiety and fear throughout their pregnancies. In the early weeks, Chloe's most pressing concerns were around her partner's apparent ambivalence to her and their child.

> *... my baby's father was not sure whether he wanted to be a father at the time, so that did not help; that put a lot of stress on me... A big stress for me was that babies feel stress from their mom, so I was trying so hard not be stressed out. (Chloe)*

Even though Sharon welcomed her pregnancy, she was still anxious about her current situation and about what lies ahead.

> *I think I was too tense and stressed throughout the majority of my pregnancy. I was afraid of something being wrong with my baby. I was afraid of not being able to provide for my baby. I was afraid about her dad and me – I had a lot of fear. Yeah. The way I look at it is that she wanted to be born and I did not want to let her go yet. I don't know... I liked being pregnant, so maybe that's what it was about ... not wanting to become mom just yet ... wanting to be pregnant a little longer. My body did not want to let her go because I was afraid of being a mom.*

Debbie, who was 38 when she got pregnant the first time, was accustomed to a life [illegible] around her own needs and desires. Being pregnant engendered anxiety about the loss of her self that is also part of motherhood

> *I went through lots of things when I was pregnant. Like resenting being pregnant because I could see that I wasn't going to be able to do things. I had to quit my job. I had never relied on a man financially and suddenly, I*

was going to be supported by my husband ... that was shocking for me to think about that. It was like I had started losing all of these little plugs and my life started getting holes, you know? I realized that I'm not going to be able to just get up and go ... I'm not going to be able to do the things that I normally do ... have a job, go out with my girlfriends when I want. I started seeing that my life was really coming to an end and that my life was going to be for someone else's for awhile.

All of the women I spoke with, described living with a heightened awareness (particularly where their children are concerned) of the potential danger that other people represent. They remain constantly vigilant, even suspicious that other people may not be what they seem. Chloe refuses to place her son in daycare. Debbie, uneasy about a "*really creepy looking man*" at her daughter's school, lingers a few moments longer than she normally might to ensure that everything is okay. If her daughter is out of her sight and begins to cry, Jane rushes to investigate no matter who is with the baby. Kate watches over her nieces, asking them frequently if anybody ever 'touches' them. Sharon was willing to be a single parent, rather than expose her daughter to a life that involved alcohol. In the throes of acute panic after the delivery of her son, Shirley's only thought was to get her son into the safe arms of his father.

These anxieties and fears influence the women's perceptions and response-ability to motherhood. As Bergum (1989) explains,

> … when there is an actual child in your life, your child, a child entrusted to you (even the child as a stranger), who is not breathing properly, who has an erratic heartbeat, who is heard crying … one is transformed by a sense of [response-ability] that subjects one to a certain terror that is not present in talk…We are shocked by our helplessness as we come face to face with the reality of illness, deformity, or death of the child we accepted in our life. (p. 84)

A 'deeper bruise of knowing'

Through participants' experiences also we get some insight into how the 'normal' anxieties of pregnancy and motherhood might be exaggerated by the deeper and sharper-

edged fear that often arises from childhood sexual abuse. For Jane, pregnancy amplified the anxiety that is a familiar feature of her everyday life.

> *When I got pregnant, I started having visions of getting hit by a car and having my body go one way and my fetus the other way or of someone stabbing me in the stomach to get rid of the baby because there was something wrong with me [choking up]. I have a lot of anxiety around that...*

Shirley, on the other hand, believes that her pregnancy put her back in touch with the terror of her childhood causing her to relive her inability to protect herself or her siblings. Shirley's response is particularly poignant, because even though her baby was *a foreign person* – (an)other with whom she felt no personal bond - she was intensely driven to protect him.

> *... because of damage by my father, it was a very disruptive pregnancy ... I didn't feel like the baby was taking control of my body. I totally felt that there was something foreign, a foreign person, inside me and I did not feel a big sense of attachment at all... It affects me even now, as I talk about it - I was afraid for anybody to touch the baby or for anybody to have any contact with the baby. Whether that was a medical person or anyone else ... (Shirley)*

Although she had not yet begun to name the horrors of her past, Elly's pregnancies both took her to the edge of emotional chaos. Like Shirley, Elly's sense of her own vulnerability in the world was closely tied to her body's reproductive capacity

> *My reproductive years were a minefield to navigate and I was glad when I knew they were definitely over. As long as I knew that I was capable of getting pregnant again, I felt like a sitting duck. I could control whom I choose to sleep with but I had no protection against rape... and rape had already been in my history. The idea of having a child ... you know that another rape that might happen... I couldn't face it.*

For both Shirley and Elly, the fears they had in pregnancy extended to their experiences of birthing.

I seriously thought I had gone to hell... My labour set off a whole series of flashbacks, for which I had no context. I was still in denial about my abuse. I seriously thought that I had gone to hell. As things progressed, an older nurse came in and sat with me. She was very good. She tried to settle my panic and talked to me about what was happening. If it had not been for her, I would have lost it completely. I was very close to being in 'screaming maniac' mode. (Elly)

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... his heart rate dropped and they had to cut me extensively ... and they had to do it fast. It seemed like there was blood everywhere. It was a bloodbath... a horrible bloody scene. A horrible, bloody scene that went back to the horrible bloody scene when I was eleven. (Shirley)

Like the subject in D. H. Lawrence's (1916) poem, *Anxiety*, these women live with a 'deeper bruise of knowing' of the world as perilous and of other people as (potentially) dangerous.

In the poem, the protagonist is standing on a vacant country road in the early morning, watching someone approach on a red bicycle. As they strain to make out who it is, we feel their growing sense of exposure and vulnerability. Is the rider someone known to them? What is the 'other' doing here? What are their intentions? Is anyone near enough to hear a cry for help? Lawrence's imagery draws us into that moment of anxiously watching and waiting; of being frozen with the anticipation of danger looming closer. Perhaps, as the rider approaches, the subject in the poem is reliving memories of a previous attack. Maybe the subject is a woman, acutely aware of being alone on a country road as a strange man approaches, paralyzed with thoughts of an impending sexual assault.

When the rider passes by without incident, the protagonist relaxes, but not completely. In those moments on that country road or at some other time in their life, Lawrence's subject has come to a personal knowing about the precariousness of human existence. Their experience of coming face-to-face with their own mortality shredded any illusions about safety in the world.

Many, if not most of us, can relate to the icy feelings of fear engendered by perceptions of real or imagined transitory danger. As we saw in Chapter 2 however, prolonged threats of harm can alter our bodies in ways that bring about long-term changes in perception, cognition, affect, behaviour, and systems of meaning. These so-called traumatic events (also called extreme stressors) are characterized by the American Psychiatric Association (2002) as involving actual or threatened death or serious injury to which an individual responds with intense fear, helplessness, or horror. Like the subject in Lawrence's (1916) poem, it is as if having glimpsed it once, an individual's mortality remains omnipresent like a shadow on the periphery of their visual field.

In writing about a sexual assault that left her near death, the philosopher Susan Brison (2002) explains how recurring feelings of powerless and fear constantly remind her that body and mind are not distinct entities. More than ten years after the incident, she still experiences her body (the object of the violence) as the enemy. It seems that the 'deeper bruise of knowing' about danger in the physical world has permanently fixed her consciousness in her body. Escaping into the "life of the mind" (p. 44) is no longer an option for her, because the two are now indistinguishable. She writes,

> [m]y mental state (typically, depression) felt physiological, like lead in my veins, while my physical state (frequently, incapacitation by fear and anxiety) was the incarnation of a cognitive and emotional paralysis resulting from shattered assumptions about my safety in the world… The intermingling of mind and body is also apparent in traumatic memories that remain in the body, in each of the senses, in the heart that races and skin that crawls whenever something resurrects the only slightly buried terror. (p. 44)

The tainted mother

As well as destroying their belief in the world as benevolent (Janoff-Bulman, 1992), childhood sexual abuse infuses a "sense of inner badness" (Harter, 1999, p. 263) into some participants' internalized working model (Bowlby, 1969, 1973) of self-in-the-world. A number of them believe(d) that this badness was constitutional, that it had always been a part of them, or that something about them had invited the abuse.

... I had a lot of guilt. I thought, "Maybe it is my fault", "If I hadn't' done this, then [the abuse] wouldn't have happened... (Chloe)

~

For a long time I thought that I was intrinsically flawed, that I came into this world somehow broken or damaged or something, and that was what drew the abuse to me. (Jane)

~

... when I was a kid I thought, "This is my fault. Why do I keep doing this to myself? (Kate)

When they became pregnant, Elly, Jane, and Shirley worried that this 'badness', made *them* dangerous to their babies.

There are times when I am afraid that I am going to 'rub off on her', that this is contagious somehow and she is going to be abused. (Jane)

~

I was really frightened for him. I was just really frightened for him and wanted him not to have anything to do with me. I wanted my husband to have the baby and nobody else ... nobody that was associated with me should have the baby... (Shirley)

~

... maybe I'm dangerous to him and he knows it. (Elly)

Her belief that she might harm her baby by being around him led Elly make a mother's ultimate "*gut-wrenching*" sacrifice; she gave the care of her son over to others who would ensure his safety and well-being.

I knew with a sharp clarity that if this kid was going to have any hope of not being damaged, I had to get the hell out of there. Within twenty-four hours of giving birth to him, I decided that I was going to leave him and then I spent the next twenty years saying goodbye to him. It was not pretty, but I knew that I could not hurt this child. (Elly)

The next chapter, *Regeneration*, shows how pregnancy, birthing, and motherhood can also be profoundly positive and healing experiences for women with histories of childhood sexual abuse.

CHAPTER 9

REGENERATION

As Debbie wisely observed, there is very little that is simple or straightforward about pregnancy and birthing; there are "*flip sides to everything*". In addition to engendering anxiety about their response-abilities, pregnancy and birthing helped women in this inquiry to tap into a new life force that changed them and how they relate in the world.

In the opening chapter of this text, I introduced Winnicott's (1986) notion about the centrality of *holding* as being essential to early infant development. As you might recall, for Winnicott, *holding* is the symbiotic engagement of mother and child that transcends actual physical holding and includes the totality of the *holding environment* (i.e., the physical realm, the relational space between them, and time). Within this dynamic, mother and child are subjectively merged - they simultaneously hold and are held by one another. This state of "absolute dependence" (p. 242) allows the infant the temporary illusion of omnipotence, of being the centre of a universe that exists only in relation to their needs. Such a mother-infant relationship creates a sturdy platform on which the infant can build a healthy self and, when they are ready, it furnishes something to push off from.

Born 'By Bits'

For participants in this inquiry, *holding and being held* by their babies through pregnancy, birthing, and motherhood was also a regenerative experience for them. The word *regeneration*, from the Latin words *regenerationem* (*being born again*) and *regenerare* (to *make over* or *generate again*) (Harper, 2001). These phrases echo Sharon's description of pregnancy and birthing as *a whole new beginning* and Jane's statement that the birth of her daughter was a *rebirth* which allowed her to become a … *whole new person*. Perhaps, it is as Mary Antin (1997) says,

> We are not born all at once, but by bits. The body first, and the spirit later… Our mothers are racked with the pains of our physical birth; we ourselves suffer the longer pains of our spiritual growth. (p. 72)

As Sharon explained to me, the safety and stability she wants for her child (and now herself) extends beyond her immediate situation. She wants safe physical surroundings, a safe family, a safe community, and a safe world.

> *I wanted stability. I want a safe environment. Not just a safe home, but a safe community ...a safe, happy, healthy environment and not just but for him and me, but for our families as well.*

For me, this statement resonates very closely with Vangie Bergum's (1997, 2007) notion of "the way of the mother" (p. 2), an ethic that moves beyond the mother-child relationship. According to Bergum,

> The *way of the mother* thus is not only about relations between women and children, but also has to do with the social fabric of society, which affects relationships between men and children, between friends and neighbours, and between acquaintances and strangers. The relational ground that is developed between mother and child (a relation necessary for the health and growth of children and mothers) is the natural ground of the impulse toward a morality of *responsibility*, in which one thinks of the other person as well as oneself- the move from *me, me, me,* to *us*. (p. 3)

Because the 'way of the mother' is antithetical to sexual abuse – to all manner of evil – it is like a soothing balm. Even the women who were reluctantly pregnant or who had difficult pregnancies and birthing experiences have benefited from its healing effects.

> *With both of my children, as soon as that child came out and was in my arms, it was like a flower just went whoosh... it's like a flower opening so full and so wide. I'd never experienced anything like it before. It was like the love that overcame me was so – I'd never experienced a love like that. It was like, 'Oh my God. This is what is meant by a mother's love' (Debbie)*

~

> *I was becoming more and more - I would not say crazy - but I certainly was not in a good place. I had a meltdown related to the abuse history... Sometime in my mid-thirties I decided that I had had enough of this dependency and I basically went off it [Valium] one winter and I don't*

think I've ever been loopier. The thing about having a child though, is that somehow through all those very, very difficult years I could think of him and stay grounded. Whenever I thought of suicide - I had promised myself that I would see my Thomas before I killed myself – I would spend time with him and somehow that pushed the thoughts of suicide away. (Elly)

~

Being with her in some way has healed me. She is such a wonderful little soul, you know. When I do sort of slip back into thinking that I am broken, I look at her and I think, 'There is no way that there could be something wrong with me if I can produce this child'. I don't know if this makes sense, but I think it is not so much seeing myself as her mother, it is also a bigger knowing that she loves me – that I am lovable and that she is my gift ... that the powers that be contrived to let me have this wonderful gift. I just have this overwhelming sense of love that I have had now for the last year and a half - ever since I found out I was pregnant. I remember the first time she moved in me; I was standing looking out the window and I had a sense of ... being carried away... It was like I was being washed clean. When I look at my daughter and how truly phenomenal she is, I feel so blessed that someone this wonderful would choose our family to come into. (Jane)

~

I have been so emotional ever since I got pregnant ... and it just doesn't stop. A touching moment on a commercial can make me tear up ... or 'Extreme Home Makeover', things like that. Even happy things make me cry and they never did before. I think it's because I have more love. I don't really think that I am a different person; certain qualities have just become stronger, I guess. Before I got pregnant, I just did whatever I want whenever I want, however I wanted, but when I got pregnant, I couldn't do that anymore. There is no way that I could, because at that moment of conception, that's when I became a mother.(Sharon)

For most of the women, a big part of their ethical responsibility to their unborn child manifest in their taking better care of themselves. Except for Shirley (who needed to avoid her body for reasons of self-preservation), this brought some of them back into their bodies in new and positive ways.—

At times during my pregnancy, I was more connected to my body. (Chloe)

~

... It was so amazing to experience what my body was doing... (Debbie)

~

I started paying more attention to my body. Things like, if I ate such-and-such, I felt better than if I ate that... Coffee would make me puke - I had always said I could never do without coffee - well I managed to do without coffee. So I was much more in tune with my physical self. I did not have a whole lot more information, but I had a different sense of my self. I think that I had a growing confidence in my ability to bring this baby into the world. (Elly)

~

When I find out I am pregnant, the first thing that I do it to make an appointment with the doctor and I always go to the Health for Two Program or whatever program there is where I'm living. I take vitamins and try to look after myself because there is another life - another human being involved. In my culture, a baby is a gift. (Kate)

~

I saw my doctor and the public health nurse regularly... Seeing them made me feel more secure knowing that I was doing the right thing... my lifestyle and working while being pregnant. I also connected with the Health for Two Program and that helped out a lot... I ate well... lots of fruits and vegetables... all of my meals, and my snacks. I have never eaten so healthily in my life. I was on my feet all day, but I thought it was okay ... you are supposed to walk lots and get lots of exercise. There was no heavy lifting involved and no chemicals - I checked the WHMIS manual and everything was okay. (Sharon)

Born Again as Mother

During their pregnancies, Jane and Sharon described a transformative change in themselves as individuals. Like Iris Young (1990), their subjective self spilt and they became keenly aware of the (an)other residing in their bodies. At the same time as their relationship with their developing babies called forth the ethical response that Bergum (2007) calls the 'way of the mother', they could not separate their babies from their selves. As they turned their loving attention to their babies it spilled over them as well. This led them not only to take good care of themselves for their babies' sakes, but to experience themselves as new beings. Through pregnancy and birthing, they were reborn.

> *I was never a mother around my abuser. He's never seen me in that role. So for me this feels pure; something that I own just myself. This is separate. I feel in some ways, not rehabilitated but, what's the word I'm looking for...? It gives me a way to reframe how I see myself ... It's such a huge break in my life; like, first you are not a mother and then you are a mother and you can never not be a mother again. I can never not be a mother again. It has really freed me because I started therapy just before I found out I was pregnant and started going through all that ... for me in some ways it wasn't just about giving birth to my beautiful daughter, it was a rebirth for me. I was ... I got to be a new person, you know? (Jane)*

~

> *... it was just a whole new beginning. (Sharon)*

As new beings, Jane and Sharon relate to their selves and the world differently. Although it does not erase their painful pasts it broadened their horizons, thereby changing their perspectives of it.

In some respects, Shirley experienced something similar through motherhood. Before she had her son she had no illusions about the work and responsibility of being a parent, what she had no idea about was the joy that mothering could bring. As her son approached his first birthday and her personal defences were firmly back in place, she began to experience the world in a new way through her relationships with her son.

> *Everything got just got better and better every year. We had a great relationship, a lot of fun. I had no parenting problems until he was about*

fourteen ... the teens were a bit complicated but not impossible. I felt that what he brought into my life was the ability to play. It was through him having his childhood and me witnessing a healthy childhood - how much he laughed - it was really wonderful... I think it's through him that I had another childhood. I mean I always was the adult but I learned how to laugh and how to scream when you're driving your cars through a tunnel. [Laughs] We used to see who could scream the loudest and the longest... I learned how to make noise with my own voice and how to sing and dance... He has a good life and he certainly helped me to have a really good life.

Through motherhood too, Debbie found a refuge, a place of belonging in the world.

I've always felt like I've never fit in; that I've never belonged. That's why I went traveling, because I thought I don't belong here and I wanted to find a home. This place feels more like home to me now. What's so outrageous for me is that it's the most normal thing in the world is to have children and a family.

For much of her son's growing up years Elly was wrestling with her own demons, while at the same time tying to reconnect with her authentic self. Although she has always maintained contact with him, he was raised day-to-day by his father and his father's second wife. Both she and her son feel sad about what they missed together and both agree that Elly did the right thing for his well-being.

My son and I have talked a lot about why I could not raise him. I think that he believes that I did the right thing. We both wish it could have been different, but it was the right thing. He is not broken ... he is not broken. He has sorrow; he sometimes feels badly about the fact that I could not be there for various things in his life, but he knows that it was the best option available to him and I at the time.

Elly speaks wistfully about a young friend who has two small children. Spending time together is bittersweet for Elly because it brings her face-to-face with what she lost in her own life. At the same time however, her time with the young family helps her to

locate the generative part of her self - the part of her self who gleefully looking forward to being a grandmother.

> *I have a young friend who just had a baby... I was so envious I could not believe myself... She has a connection to her baby that is completely different from what I had. I love spending time with her... I really enjoy watching her with her babies. It gives me a great deal of pleasure and comfort to know that I could have done that had my situation been different. I could have been that in love with my baby. I could have enjoyed, you know, all the pleasures of having a small child. I am going to be a wickedly engaged grandmother. I have already warned my son, they will never get rid of me!*

A Return to Wholeness

My conversations with the women sent me searching for a quote by Carl Jung (1938) that I read a number of years ago:

> All of the greatest and most important problems in life are fundamentally insoluble … They can never be solved, but only outgrown. This "outgrowing" proved on further investigation to require a new level of consciousness. Some higher or wider interest appeared on the patient's horizon, and through this broadening of his or her outlook the insoluble problem lost its urgency. It was not solved on its own terms but faded when confronted with a new and stronger life urge. (paras. 18)

Although sexual abuse and other types of childhood adversity may profoundly damage some aspects of a woman, pregnancy, birthing, and/or motherhood excites a life force that re-empowers her and reconnects her to her self, to other people, and to the world. Pregnancy and birthing are 'higher interests' that broadened the women's perspective, bringing new meaning to their lives. Through the dynamics of holding and being held by their infants, the women were reborn to an awareness of their own childhood innocence and personal worth. While pregnancy and birthing do not erase memories of the past or even resolve its residual effects in the present, through them women regenerate connections to the goodness that does exist in the world and in other people.

As I have said elsewhere, Judith Herman (1992) believes that because the harm of childhood sexual abuse is interpersonal, remediation of that harm

> … can take place only in the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the [woman] re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include basic capacities for trust, autonomy, initiative, competence, and intimacy. Just as these capabilities are originally formed in relationships with other people, they must be reformed in such relationships. (p. 133)

What is unique about the relationship that develops between a woman and a child she carried in her womb is that, for a time, the child is simultaneously both her *self* and *other* (Young, 1990). Theirs, according to Wynn (1996), is an "intercorporeal relationship in which both flex and bend toward each other and inscribe each other, yet retain their own particularity" (p. 169). As she cares for her unborn baby, the woman necessarily cares for herself. As she considers her child's innocence and goodness, she must also contemplate those things in herself. Jane explains it this way,

> *... it was one of the first purely joyful periods in my life. There was this beautiful little baby that I got to bring into the world and watch over and help grow into this amazing human being, you know? I mean I had fears and the visions, but more than anything it was just this incredible sense of joy ... There was also this incredible sense of peace. Not exactly that I had another chance, but that I can watch a little girl grow up and see all of the wonderful things that happen. I can protect her, so I can still be a part of a little girl growing into a woman safely, you know? ...But when I had Emma, I realized that we all come into this world perfect, and that the flaw wasn't in me, it is in my abusers. It has been really difficult giving up this long-held belief that there was something wrong with me. I still ... I mean there's still pieces of it that I haven't gotten rid of ... but having Emma has allowed me to see myself differently.*

In the relational space of holding and being held, women with histories of childhood sexual abuse often find wholeness.

Interestingly, the etymological roots of the words *health* and *healing* originate in the Old English word *haelen*, meaning *to be* or *to become whole* (Quinn, 1989; Rootman & Raeburn, 1994). We can see this idea of 'health as wholeness' carried forward into the current century in Simpson's (2007) definition of 'health' as *soundness of mind or body* and of 'healing' as *restoration of health.* Rosemary Parse (1992) describes healing as a *process of human becoming* (i.e., of becoming more fully human), while Medich and colleagues (1997) are more explicit about healing as coming about through

> ... the processes of bringing together some complex, internal, and external human responses with past and present biologic, psychologic, social, spiritual, and behavioral experiences for the individual to achieve new life meaning, growth, and development. (p. 66)

In the natural world, generativity is an ongoing process. Every ending is the beginning of something new, just as every beginning holds the seeds of its demise. Generation and regeneration is the teleological principle of this thing that we call *life force*. Life begets life, and as Juliet declares to Romeo, love begets love.

> My bounty is as boundless as the sea,
> My love as deep; the more I give to thee,
> The more I have, for both are infinite. [28]

[28] Act II, scene 2 of *Romeo and Juliet* (Shakespeare, 2005)

CHAPTER 10

A 'GOOD GESTALT':

Reflections on the Inquiry Process

The aim of this inquiry has been to address the question: *What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?* Through prolonged and discursive conversations with individuals, various literatures, and other sources of information, I have endeavoured to create a rich, descriptive, and evocative text that contributes to our understanding of the lived experience of these women. My hope is that this work, as van Manen suggests (1997), "... may have certain effects on the people with whom the research is concerned..."; that it invites nurses and other health care providers to reflect on their practice. And further, that those reflections lead to an increased sensitivity to the experience of women with histories of childhood sexual abuse.

From the outset the question pulled insistently at both my professional and personal selves. In my efforts to keep it open, other questions presented themselves. How is childhood sexual abuse understood by Western society, now and in the past? What are its implications for a developing self? How is it experienced physically, psychologically, emotionally, and spiritually? What makes it such a salient experience in an individual's life? What is the history of modern maternity care and how do its practices relate to women's childbearing experience? What is pregnancy and birthing like for women? Does childhood sexual abuse influence the experience of pregnancy and birthing? If so, in what ways? My explorations of these other questions led me to historical texts; to the psychological, sociological, medical, and nursing literatures; to other fictional and non-fictional works; and to poetry. A portion of what I learned in the process comprises the background chapters of this work. Throughout my engagement with these various materials, I repeatedly turned back to the question at the centre of this inquiry and asked, '*What does this reveal to me about women's lived experience?*'

Other important aspects of this inquiry were the conversations I had with other people about these topics. Some occurred in formal settings (e.g., professional conferences, workshops, and meetings), while others were casual exchanges with friends and colleagues. I found it interesting and affirming that when I talked with people about

my project, none of them seemed to doubt its importance to the discipline of nursing. Women – family, friends, colleagues, and even strangers – were eager to tell me their own stories about pregnancy and birthing. All of these exchanges stimulated my thinking and many pointed out new avenues for further research. When I began recruiting women to formally share their stories of pregnancy and birthing, the responses came quickly.

After months of reading, conversing, thinking, writing, and rewriting, I find myself facing another question – *Have I achieved what I set out to do?* While others who read this text will reach their own conclusions, I can say without equivocation that my own understanding of the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse is deeper, richer, and more textured. At the same time however, there is much I do not yet understand. I continually remind myself that the goal of interpretive inquiry is not definitive answers; they do not exist for many of life's most important questions. Rather, to revisit a quote from Parker Palmer (1998), the goal is to be engaged, "… in an eternal conversation about things that matter, conducted with passion and discipline … truth is not the conclusions so much as it is the process of conversation itself … if you want to be in truth you must be in conversation" (p. 104).

The word *engage*, from the Old French *en gage*, translates literally as *under pledge*, inferring a binding promise or contract - as in being *engaged to marry*. In the intransitive sense, *to engage* is to *involve one self, to be occupied with*, or *to participate with* (Harper, 2001; Simpson, 2007). My engagement with the research question and with the various texts and individuals I consulted created a dialectical tension that led me further into the question; into the transcripts; into the literatures on childbearing, human development, and psychological trauma; and into my own experience. This pursuit of understanding transcended particular women's experiences and revealed new insights into the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse. These are captured in the themes of *living in the wake of childhood sexual abuse, response-ability to motherhood,* and *regeneration.*

My decision to end this project here is based on two things – the limitations imposed by a doctoral program and Kvale's (1996) contention that while the interpretive process is never fully complete, it ends when the researcher has "reached a 'good

Gestalt'" (p. 48). This occurs when the researcher's understanding of the phenomenon of interest has inner unity, coherence, and consistency.

A 'Good Gestalt'

I think that I glimpsed my 'good Gestalt' sometime during my first conversational interview, which was with Sharon. She called and volunteered to speak with me the very day that the ad for this study appeared in a local publication. As I drove to her house I wondered where our conversation would take us. Would she want to focus exclusively on her experience of sexual abuse and its implications in her current life? I could feel my anxiety rising slightly as I thought about ways to turn our talk to her experience of pregnancy and birthing.

From the moment I walked into Sharon's cozy, basement apartment I was aware of her daughter's presence, even though the child was asleep in another room. References to the infant were everywhere – colourful toys in the corner of the living room, plastic baby bottles drying on the kitchen counter, photographs of her on almost every surface, and the baby monitor that Sharon set on the table between us. Static from the small plastic receiver crackled softly as we tentatively negotiated how we would be together in this encounter. As my ears accommodated to the sounds emitting from the device on the table in front of me, I ceased hearing them. The anxiety I had about the direction our conversation would take dissipated as Sharon animatedly launched into telling me about her childbearing experience.

Suddenly, the young mother froze in mid-sentence and cocked her head slightly. She was very still, hardly breathing. I studied her face, searching for some indication about what had just happened. Was she upset? Had she forgotten what she was about to say? I was about to ask, when her body relaxed and she exhaled. "She is just a bit restless, but I think she will go back to sleep," she explained and I understood that Sharon had been orienting to sounds coming from the baby monitor. Sounds that I had completely missed, but ones that her finely attuned 'mother ears' heard and shuttled directly to her higher brain centres for analysis. My mind immediately flashed to the title of one of Vangie Bergum's (1997) books, *A Child on her Mind*. Although Sharon's daughter was not physically present, she was omnipresent - in this home and in the young mother's consciousness. When I asked Sharon about this, she replied

I have loved lots of children and I have worked with hundreds of children, but to have your own baby calling 'Mom', even if you are tired and trying to sleep, when you hear 'Mom. Mom. Mom', you just forget about everything and, it's like, "My baby is awake. My baby wants me' and you know ... that's what I'm here to do.

After I left Sharon's home, I parked on a quiet side street to think about our encounter. There was something about it … something intriguing or unexpected that I could not quite put my finger on. I rewound the tape in my hand-held tape recorder and settled back to listen to our conversation.

In my training as a psychotherapist one of my mentors drilled into me the importance of attending to *how* an individual says something, as much as I do to the actual content. What is their tone of voice like? Do their words form so quickly that tongue and lips have trouble keeping up, or conversely, are words formed slowly, punctuated by long pauses or deep sighs? What are the person's eyes doing? Are they bright, sparkly, and engaged or dull and disinterested? How do they seem in their body? Are their movements fluid and graceful, quick and jerky, or slow and heavy? What is their breathing pattern like? Most importantly, this teacher coached me to notice what topics are associated with the highest levels of energy.

Having practiced these things for years, I am hardly aware of doing them, but as I listened for the inflections in Sharon's voice and to the energy of her words I 'heard' anew what she had just told me. She spoke only in passing about her history of abuse and even then, only to explain how it influenced her present experience as a mother. While I got hints that some aspects of her childhood experience affect her even today, her response to my invitation to tell me about her experience of pregnancy and birthing did not prompt her to go there. What she really wanted to tell me was how having her daughter was a *whole new beginning* for her, how pregnancy and birthing her daughter had transformed her.

Relevance of the Inquiry to Nursing Practice

Through the themes of *living in the wake of childhood sexual abuse, response-ability to motherhood,* and *regeneration*, this text reveals the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse.

Living in the wake of childhood sexual abuse reveals how childhood sexual abuse can insinuate itself into a life, sometimes causing long-term disruptions in mood and affect, perceptions, beliefs, behaviour, and systems of meaning. The women's narratives breathe life into what Finkelhor and Browne (1985) call the *traumagenic dynamics* of childhood sexual abuse - powerlessness, betrayal, stigmatization, and traumatic sexualization. Through the women's descriptions we see how these dynamics etch a body and a psyche with uncertainty and fear, fracture beliefs, and even 'undo' a self. We hear too, that for some women, another aspect of *living in the wake of childhood sexual abuse* is resilience and healing.

Through the theme of *response-ability to motherhood*, the women revealed how pregnancy brought them new ways of seeing and relating to themselves and to the burden of responsibility for (an)other's well-being. Their life circumstances at the time they became pregnant influenced their perceptions of themselves and their response-abilities to motherhood. Those who described feeling safe, stable, and supported, often felt a visceral 'Yes!' to being pregnant. When those things were absent however, women were more apt to be uncertain about pregnancy or to experience pregnancy as an invasion. As well, the women spoke of how their response-ability to pregnancy was coloured by an indelible 'knowing' first-hand, about the dangers that exist for children in the world.

Pregnancy and birthing can also be times of *regeneration* for women with histories of childhood sexual abuse. Their narratives reveal how carrying, birthing, and caring for a child opens them up to previously unimagined ways of being, to lost innocence, and to the delights and joys of childhood, which in turn offered them new opportunities for wholeness and healing.

Vulnerability and openness

Vangie Bergum (1998, 996, 2007) has written extensively about the transformation from woman to mother that occurs through pregnancy and birthing. The movement from one way of being (woman) to another (mother) requires finding safe passage through a state of *liminality*, which is typified by unsteadiness and uncertainty (Heilbrun, 1999). In that state, energies and forces that support and shape a life loosen; defences soften and even fall away. When she is pregnant, a woman's life folds back on itself and her past, present, and future are accessible to her in new ways. As well as being

a time of more openness (Simkin & Klaus, 2004), pregnancy is also a time of vulnerability; a time when relationships - particularly relationships with health care providers can take on new significance.

Recall how Sharon and Kate both looked to pregnancy outreach services as soon as they learned that they were pregnant. As well as concrete assistance with maternity clothing, a bus pass, and milk coupons, Sharon spoke of being

> *thankful, not only for the information, but for the nurse to be able to come over and sit and have coffee and talk about what was going on with me.*

Through these conversational exchanges, the nurse was undoubtedly 'assessing' various aspects of Sharon's health, but she did it in such a way that the young woman felt seen and heard, cared for. On the other hand, many times throughout this inquiry, I was saddened and even shocked to hear and read how little support other women receive from nurses and other healthcare providers.

Shirley was "*...at complete odds...*" with her caregivers and while Jane has a very positive relationship with her physician and the nurse who works in his office, she described the nurses in the hospital as "*horrible*".

> *There was no sort of sensitivity, no sort of softness or gentleness or anything...there was no sort of recognition... about the needs that I had as a person who didn't have boundaries for years and years and years... There was no recognition that I might need more time to adjust to a small baby on my breast that other women don't need... Eventually I just made my Mum get my stuff and I left. It was really awful. Having my defences down, made a bad experience much worse. I think I was especially vulnerable because... I had just had this beautiful new baby girl... so a whole bunch of defences that I would normally have up, weren't... Having my defences down, made a bad experience much worse.*

Above all, do no harm

In the healthcare encounter, nurses and other healthcare providers hold the balance of power by virtue of their professional status and specialized knowledge. This, along with the fact that interpersonal relationships are a source of both trauma and healing, makes the healthcare of women with histories of sexual abuse an ethical concern

as much as it is a clinical one. Encounters with caring and supportive healthcare providers can be part of the substrate – the nutrient medium - for healing the parts of the self damaged by childhood sexual abuse. Through sensitive and caring relationships, individuals harmed by childhood sexual abuse can rebuild their basic capacities for autonomy, trust, and intimacy. The corollary is also true as we saw from Jane, Elly, and Kate's narratives. Ill-informed and insensitive healthcare providers can also exacerbate the harm caused by childhood sexual abuse.

Because the existing research evidence is clear about the high incidence and prevalence of childhood sexual abuse (particularly among girls and women), it is reasonable for clinicians in every specialty to assume that they encounter these individuals every day in their practice. While most healthcare providers will not develop the specialized knowledge and skills needed to work intensively with individuals with histories of abuse through their healing, it is important that all practitioners understand the dynamics and (potential) long-term health effects of interpersonal trauma so that they can respond sensitively.

Sensitive practice: Substrate for healing

Through other projects that I am involved with [Schachter, Stalker, & Teram, 2000; Schachter, Stalker, Teram, & Lasiuk, (in review)] I have come to understand the nature of sensitive practice with individuals affected by childhood sexual abuse. In these projects, my colleagues and I have spoken with hundreds of women and men with histories of abuse from across Canada, about their experiences in health serving environments. What we have heard is a clear message about the importance of interpersonal safety. Many individuals described experiences in which they felt unsafe in health-serving environments and in their relationships with healthcare practitioners.

Before I joined this group, the others (Schachter et al, 2000) adopted the image of an umbrella to conceptualize safety, with the principles of sensitive practice being the frame that supports it. Those principles include respect, rapport, sharing control, sharing information, respecting boundaries, fostering mutual learning, acknowledgement of the ebbs and flows of healing, and demonstrating an awareness of the prevalence and sequelae of violence and trauma.

During interviews and focus groups, healthcare providers told us about their lack of knowledge about the dynamics of childhood sexual abuse and their resultant anxiety about broaching the topic with their patients or clients. At the same time, many individuals with histories of sexual abuse were telling us that they do not want to disclose the details of their past abuse to healthcare providers, as most of them have others in their life for that. What the latter do want however is for *all* healthcare providers to know about the dynamics of childhood sexual abuse and its potential effects, and to interact with them sensitively. Examples of this include: announcing oneself before entering a room or cubicle *and waiting for permission before proceeding in*; ensuring privacy; minimizing physical exposure; asking permission before touching; explaining what you intend to do before you do it. During longer or difficult procedures, individuals want to be asked frequently how they are doing and for the clinician to respond accordingly (i.e., to slow down, take a break, or stop). Like most of us, those with histories of childhood sexual abuse want to be seen and acknowledged as individuals.

Concluding Comments

Through this inquiry process, it has become increasingly clear to me that along with a woman's partner and supportive family and friends, her relationships with healthcare providers can facilitate her safe passage into motherhood. I have come to understand too, that relationships have particular significance in the lives of women with histories of sexual abuse because of their close associations with both harm and healing. Furthermore, I am convinced that by virtue of their specialized knowledge and greater social position, all healthcare providers have an ethical and professional responsibility to know about the health effects of childhood sexual abuse and about what it means to relate sensitively with those to whom they provide care.

Although this inquiry is at an end, the question that initiated it and those that arose along the way remain open in my own mind and, I hope, in the minds of those who read this text. As Bergum explains (1989) this

> … means keeping open the search for understanding, constantly questioning what is taken as secure, accepting that there is always more to learn, searching for another view of the complex reality of living – which may open further depths of questioning and understanding. (p. 153)

As I look ahead to where my continuing journey of inquiry may lead, I think of possible ways to share what I have learned with others through writing, conversations with colleagues, students, and women who have an interest in this question.

I leave the closing comment to Christine (1994), the woman whose voice called me in to the conversation that is this text.

> *If you are a [healthcare practitioner[29]], my advice to you is to ask [every woman] if she has been sexually abused. Ask with the courage to know. Listen with the compassion to really hear. Not every woman who comes to you with a history of [sexual abuse] will remember or know about her abuse, but she may tell you in other ways. She may tell you with her tears, her pain, her fear. Please treat her gently, lest you repeat the abuse in a more subtle way. If she cannot talk about it, do not force her. She will know when she is ready. Just as in birth, this is about trusting the process. You will not have all the answers for her. That is OK; she is finding her own answers... teach us to trust our bodies, help us to know ourselves. I believe that [healthcare providers] can help us heal.*

[29] Christine (1994) addresses her these comments specifically to midwives. I have taken the liberty here of broadening what she says to all healthcare providers.

EPILOGUE

An epilogue, from the Greek word *epilogos* (*epi-* in addition + *logos* - word, speech, discourse; Harper, 2001) refers to an addendum to a literary work or a play and is intended to bring closure to the work. An epilogue may also convey the moral of the story or précis lessons to be learned from it. My intent is to do that here by responding to two questions put to me during my final defence of this project: *What is unique about the experience of pregnancy and birthing of women with histories of childhood sexual abuse? What can an understanding of this 'uniqueness' offer to other women who have had similar experiences?*

My answer to the first question is 'nothing' and everything'. The great paradox of childhood sexual abuse is that while it is increasingly in the public awareness, it remains steeped in secrecy. Women who were sexually abused as children live among us, yet for the most part, they are invisible to us as less than half of them disclose their abuse to anyone (Finkelhor, 1994; Matthews, 1995). Some remain silent because they fear reprisal from their abuser(s), while others worry that no one will believe them, that they will be blamed, or even punished (Engel, 1999). Still others say nothing because they harbour the belief that they are responsible for what happened to them.

When these women become pregnant, they do so by the same means that all other women do – through sexual intercourse or by some assisted means (e.g., Assisted Reproductive Technology). Whether conception occurs - by choice or 'accidentally', in the throes of passion or by coercion, is perceived as a blessed event or a nightmare - once the fertilized ovum nestles into the lining of the uterus their bodies' innate wisdom orchestrates the myriad physiological changes necessary to create and birth a new life. Throughout pregnancy, they have many of the same feelings that all women do – excited anticipation, joy, love, anxiety, self-doubt, and a profound sense of responsibility. What is unique however, what makes their experience of pregnancy and birthing qualitatively different from women who have not been abused, is their first-hand knowledge of the world as a dangerous place.

When childhood sexual abuse destroys a girl's fundamental assumptions that the world is benevolent and meaningful and that she is a worthy being (Bulman, 1992), it rips away the mantle of existential denial that most of us live with. Without it, she no longer

has the protective illusions that evil is theoretical, that bad things will not happen to her or the ones she loves, and that trusted others will always protect her. Having lived it, her knowledge of human vulnerability remains omnipresent, casting a permanent shadow over her visual field that colours everything that comes afterward.

Women who were sexually abused as children never feel completely safe in the world and never completely trust other people. Jane offered an example that epitomized this when she told me that whenever she hears her daughter crying she always goes to her, even when the child is with her father. This is significant, because if you recall, Jane is in a relationship in which she feels secure and loved by a man who is very protective of her, a man who was the first person to stand up for her against her abuser. Despite this, she said

> *Even now, if he's feeding her and ... she starts to cry a little bit, I have to go up and make sure that he's not touching her... and like I trust my baby's father with my life...*

So even though she trusts her partner with her own life, Jane cannot shed the doubt that she can trust him completely with their daughter.

An understanding of the uniqueness of the experience of pregnancy and birthing of women with histories of childhood sexual abuse can offer other women the sense that they are not alone. Reading and hearing other women's stories may help them to appreciate that childhood sexual abuse is often traumatic and can have both short- and long-term consequences. Connie[30], a woman I worked with as a client, offered the following analogy. "My life" she told me "is like a stack of coins. One of the coins near the bottom of the stack is out of alignment, causing all of the coins on top of it to skew slightly. That coin – the one that is out of kilter – represents the abuse in my childhood. Everything that has happened to me since is affected by it."

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[30] Pseudonym

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APPENDIX A

Participant Information Sheet

Project Title: The Lived Experience of Pregnancy and Birthing of Women with Histories of Childhood Sexual Abuse

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What is the purpose of the study?
To understand how women with histories of childhood sexual abuse experience pregnancy and birthing.

Who can participate?
Women who …

- have a history of childhood sexual abuse
- have experienced pregnancy and birthing but are not currently pregnant
- speak English
- are 18 years of age and older

What is involved?

- 1 or 2 conversations about your experience of pregnancy and birthing
- Conversation will last 1 – 2 hours at a convenient time and place
- I will not ask women to talk about past abuse
- The conversations will be taped recorded and transcribed.

Are there any risks?

- Some women may feel upset after talking about things that remind them of difficult past events. If this happens, I will offer immediate support and help them find ongoing support/treatment if necessary.

Are there any benefits?

- Talking about life experiences with an empathetic and supportive health professional
- Being part of research that may help to improve women's health care.

What about confidentiality?

- All information will be held in strict confidence **except** if a woman tells me that she intends to harm herself or someone else.
- All project materials (e.g., consent forms, audio tapes, and transcripts) will be stored in a locked cabinet, in a locked office for 5 years after the project is completed and then destroyed (University of Alberta Research Policies and Services Manual, sections 5.2 and 7.5).
- If the information for this study is used to help answer other research questions, it will undergo another review by the University of Alberta HREB to ensure that the information is used ethically.

If you have any questions or concerns about this project, please call Dr. Kathy Hegadoren (780) 492-4591, Dr. Wendy Austin (780) 492-5250, or the Institutional Review Board at the University of Alberta, Edmonton, AB. Phone (780) 492-0839.

APPENDIX B

Participant Consent

Project Title: The Lived Experience of Pregnancy and Birthing of Women with Histories of Childhood Sexual Abuse

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Do you understand that you have been asked to be in a research study?
Yes No

Have you read and received a copy of the attached Information Letter?
Yes No

Do you understand the benefits and risks involved in undertaking part in this research study?
Yes No

Have you had an opportunity to ask questions and discuss this study?
Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.
Yes No

Has the issue of confidentiality been explained to you? Do you understand who will have access to your record, including personally identifiable health information?

Yes No

This study was explained to me by:

_____ Date: _____2005

I agree to take part in this study.

Signature of Research Participant_____

Printed Name: _____

Witness: _____ Printed Name: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher: _____ Printed Name: _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

IF YOU WISH TO RECEIVE A SUMMARY OF THE STUDY WHEN IT IS FINISHED, PLEASE COMPLETE THE FOLLOWING:

NAME: _____

ADDRESS: _____

_____

_____

_____